DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES
ADDICTIVE AND MENTAL DISORDERS DIVISION

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September 18, 2006

Centers for Medicare and Medicaid Services – Region VIII
Attn: George Mills, Acting Regional Administrator
Colorado State Bank Building
1600 Broadway, Suite 700
Denver, CO 80202

Dear Mr. Mills:

The Montana Department of Public Health and Human Services, Addictive and Mental Disorders Division, is pleased to submit a Section 1915 (c) Home and Community Based Services Waiver application for adults with severe disabling mental illness. The comparison population is nursing facility and as such, participants in the waiver must meet nursing facility level of care and meet severe disabling mental illness criteria. The State is requesting the following provisions of the Social Security Act to be waived:

Section 1902(a)(1), regarding statewideness; and
Section 1902(a)(10)(B), regarding comparability of services.

Addictive and Mental Disorders Division staff are extremely appreciative of the guidance and technical assistance provided by the following CMS staff: Mary Kissell and Diane Lorengo-Volk (Denver) and Mary P. Sowers and April Forsythe (Baltimore). They are delightful individuals knowledgeable in their fields.

Please contact the following staff in the Addictive and Mental Disorders Division staff if you have questions: Jane Bernard (406-444-9530), Lou Thompson (406-444-9657), or Joyce DeCunzo (406-444-3639). We look forward to this new opportunity and providing adults with severe disabling mental illness a choice to receive long term care services in the community.

Sincerely,

John Chappuis, Deputy Director
State Medicaid Director

C Jane Bernard
Lou Thompson
Joyce DeCunzo
Mary Kissell – Denver CMS

Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.3

Submitted by:

Montana Department of Public Health and Human Services, Addictive and Mental Disorders Division

Submission Date:	September 18, 2006

CMS Receipt Date *(CMS Use)*	

Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment):

Brief Description:
We are pleased to submit this request for a new 1915 (c) waiver for adults age 18 and over with severe disabling mental illness (SDMI) who, without waiver services, would be in nursing homes. The SDMI Waiver will not be available statewide; there is capacity for 105 slots per year.

Application for a §1915(c) Home and Community-Based Services Waiver

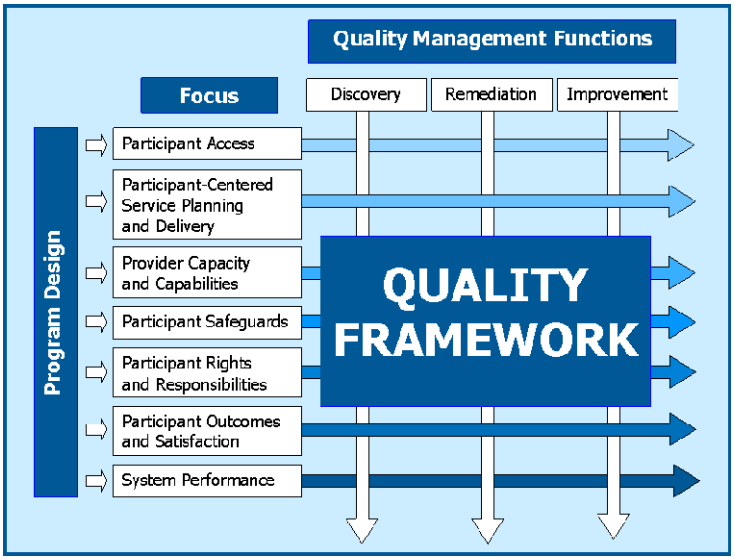
PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

The waiver application is based on the HCBS Quality Framework. The Framework focuses on seven broad, participant-centered desired outcomes for the delivery of waiver services, including assuring participant health and welfare:

- **Participant Access**: *Individuals have access to home and community-based services and supports in their communities.*
- **Participant-Centered Service Planning and Delivery**: *Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.*
- **Provider Capacity and Capabilities**: *There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
- **Participant Safeguards**: *Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
- **Participant Rights and Responsibilities**: *Participants receive support to exercise their rights and in accepting personal responsibilities.*
- **Participant Outcomes and Satisfaction**: *Participants are satisfied with their services and achieve desired outcomes.*
- **System Performance**: *The system supports participants efficiently and effectively and constantly strives to improve quality.*



The Framework also stresses the importance of respecting the preferences and autonomy of waiver participants.

The Framework embodies the essential elements for assuring and improving the quality of waiver services: design, discovery, remediation and improvement. The State has flexibility in developing and implementing a Quality Management Strategy to promote the achievement of the desired outcomes expressed in the Quality Framework.

1. Request Information

A. The **State** of **Montana** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Waiver Title (*optional*): Behavioral Health Waiver for Adults with Severe Disabling Mental Illness (SDMI Waiver)

C. Type of Request *(select only one)*:

✓	**New Waiver (3 Years)**	CMS-Assigned Waiver Number (*CMS Use*):	
○	**New Waiver (3 Years) to Replace Waiver #**		
	CMS-Assigned Waiver Number (*CMS Use*):		
	Attachment #1 contains the transition plan to the new waiver.		
○	**Renewal (5 Years) of Waiver #**		
○	**Amendment to Waiver #**		

D. Type of Waiver *(select only one)*:

○	**Model Waiver**. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
✓	**Regular Waiver**, as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date: October 1, 2006

E.2 Approved Effective Date *(CMS Use):*

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan *(check each that applies)*:

☐	Hospital *(select applicable level of care)*	
	○	Hospital as defined in 42 CFR §440.10. If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
	○	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
✓	Nursing Facility *(select applicable level of care)*	
	✓	As defined in 42 CFR §440.40 and 42 CFR §440.155. If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
	○	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
☐	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:	

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities *(check the applicable authority or authorities)*:

☐	Services furnished under the provisions of §1915(a) of the Act and described in Appendix I			
☐	Waiver(s) authorized under §1915(b) of the Act. *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*			
	Specify the §1915(b) authorities under which this program operates (*check each that applies*):			
	☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
	☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)
☐	A program authorized under §1115 of the Act. *Specify the program:*			
✓	Not applicable			

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Behavioral Health Waiver for Adults with Severe Disabling Mental Illness (SDMI Waiver) is designed to provide a consumer with SDMI a choice of receiving long term care services in a community setting as an alternative to receiving long term care services in a nursing home setting. The consumer must meet nursing home level of care and reside in an area of the state where the SDMI Waiver is available.

The objective of the SDMI Waiver is rehabilitation and recovery, while encouraging the consumer to accept personal responsibility for services and desired outcomes. The State will ensure the providers of HCBS services possess and demonstrate the capability to effectively serve consumers with SDMI.

Concurrently, another goal includes providing quality care while maintaining financial accountability. SDMI Waiver providers will be enrolled Montana Medicaid providers and all payments will occur through the MMIS. The providers of waiver services receive payments directly and providers retain 100% of these payments. Public and non-public providers receive the same amount of Medicaid reimbursement. There are no intergovernmental transfer policies or certified public expenditures of non-state public agencies included within the SDMI Waiver.

The goal of providing quality care while maintaining financial accountability will be accomplished by:
-Conducting quality assurance reviews;
-Conducting satisfaction surveys with waiver enrollees;
-Completing regular audits of SDMI Waiver providers' records for compliance;
-Providing training/education to all waiver providers; and
-Monitoring all waiver expenditures.

The SDMI Waiver will not be available statewide and will be located in three geographical areas based on an urban core. Those areas are Yellowstone County (including counties of big Horn, Carbon, Stillwater and Sweet Grass), Silver Bow County (including counties of Beaverhead, Deer Lodge, Granite and Powell) and Cascade County (including counties of Blaine, Chouteau, Glacier, Hill, Liberty, Pondera, Teton and Toole).

The package of services to be included in the SDMI waiver are: Case Management, Adult Residential Care, Supported Living, Adult Day Health, Personal Assistance and Specially Trained Attendant Care, Habilitation, Homemaking, Respite Care, Outpatient Occupational Therapy, Psycho-Social Consultation including extended Mental Health Services, Chemical Dependency Counseling, Dietetic and Nutrition Services, Nursing Services, Personal Emergency Response Systems, Specialized Medical Equipment and Supplies, Non-Medical Transportation, Illness Management and Recovery, and Wellness Recovery Action Plan. Services are reimbursed fee for service; there is no managed mental health plan.

The Department of Public Health and Human Services, Addictive and Mental Disorders Division is the lead agency for the operation of the SDMI waiver. The State Medicaid Director is also the Deputy Director for the Department of Public Health and Human Services.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. *(Select one)*:

❍	The waiver provides for participant direction of services. *Appendix E is required.*
✓	Not applicable. The waiver does not provide for participant direction of services. *Appendix E is not completed.*

F. Participant Rights. **Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Management Strategy. Appendix H contains the Quality Management Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

○	Yes
✓	No
○	Not applicable

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

✓	**Yes** *(complete remainder of item)*
○	**No**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

✓	**Geographic Limitation**. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. S*pecify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area*:
	The SDMI Waiver will not be available statewide and will be located in three geographical areas based on an urban core. Those areas are Yellowstone County (including counties of big Horn, Carbon, Stillwater and Sweet Grass), Silver Bow County (including counties of Beaverhead, Deer Lodge, Granite and Powell) and Cascade County (including counties of Blaine, Chouteau, Glacier, Hill, Liberty, Pondera, Teton and Toole.
☐	**Limited Implementation of Participant-Direction**. A waiver of statewideness is requested in order to make ***participant direction of services*** as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. *Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area*:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services.

Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan

and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected amount, frequency and duration and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.51, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Management. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity

and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Management Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:

Service Area Authorities (SAA) were established by the Montana Legislature as stakeholder entities for the purpose of collaboration with the Department of Public Health and Human Services (Department) for planning and oversight of mental health services. There are three SAAs, each of which has a board of directors with a majority of members who are consumers of mental health services and family members of consumers. The Addictive and Mental Disorders Division has met with each of the SAA Boards as well as with a group of consumer delegates regarding the development of the waiver. Information will be posted on the Department's website for the general public's review and opportunity to comment. Administrative Rules of Montana have been proposed and, as part of the state's required review process, a public hearing has been held to provide information about the waiver and to solicit oral and written comments before the proposed rules are finalized.

The Department has notified in writing all federally-recognized Tribal Governments regarding the intent to submit an application for a home and community based services waiver. The Tribal entities were notified officially on July 3, 2006 and provided 30 days to submit their comments and views. The Department offered to meet with Tribal entities at their request.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Lou
Last Name	Thompson
Title:	Chief, Mental Health Services Bureau
Agency:	Montana Department of Public Health and Human Services Addictive and Mental Disorders Division
Address 1:	PO Box 202905
Address 2:	555 Fuller
City	Helena
State	Montana
Zip Code	59620-2905
Telephone:	406-444-9657
E-mail	lothompson@mt.gov
Fax Number	406-444-4435

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2	
City	
State	
Zip Code	
Telephone:	
E-mail	
Fax Number	

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: _____ **Date:**

State Medicaid Director or Designee

First Name:	John
Last Name	Chappuis
Title:	State Medicaid Director
Agency:	Montana Department of Public Health and Human Services
Address 1:	PO Box 4210
Address 2:	111 North Sanders
City	Helena
State	Montana
Zip Code	59602-4210
Telephone:	406-444-4084
E-mail	jchappuis@mt.gov
Fax Number	406-444-1970

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Not applicable

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver *(select one)*:

✓	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one; do not complete Item A-2*):
	○ The Medical Assistance Unit *(name of unit)*:
	✓ Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (name of division/unit): Addictive and Mental Disorders Division
○	The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *Complete item A-2.*

2. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the waiver operating agency (if applicable) (s*elect one)*:

✓	**Yes.** Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*

	The Mountain Pacific Quality Health Foundation (MPQHF) will conduct the level of care assessments, including Level I activity. As appropriate, MPQHF will refer individuals to the waiver case management teams. MPQHF is a QIO. Community Mental Health Centers will complete the Level II screens for individuals who are identified by MPQHF as having mental illness. The Level II screen will determine if active treatment is necessary. Community Mental Health Centers will determine if SDMI criteria are met and advise MPQHF. ACS (Affiliated Computer Systems), the Department of Public Health and Human Services' fiscal agent for MMIS, will adjudicate the claims for waiver providers. ACS will assist providers of waiver services with enrollment. Case Management Teams will enroll individuals in the SDMI Waiver and provide case management services. Case management teams will work within the communities to identify providers of waiver services appropriate to meet the needs of enrollees in the waiver.
○	**No**. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity *(check each that applies)*:

☐	**Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these agencies and complete items A-5 and A-6:*
☐	**Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a **contract** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these entities and complete items A-5 and A-6*:
✓	**Not applicable** – Local/regional non-state agencies do not perform waiver operational and administrative functions.

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

Department of Public Health and Human Services, Addictive and Mental Disorders Division will be responsible for assessing the performance of contracted entities.

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The Mountain Pacific Quality Health Foundation will submit a Management Report to Addictive and Mental Disorders Division (AMDD) of the Department of Public Health and Human Services on a quarterly basis. The report will capture data on the date of level of care assessments, the outcome of the assessments and days elapsed between the request for level of care determination and the date the letter was sent to the applicant notifying him/her of the PASARR level of care determination outcome. AMDD will monitor the report to ensure that assessment and information regarding level of care determination is provided in a timely manner. AMDD will periodically review a sample of level of care determinations to ensure accuracy and consistency in the application of the level of care instrument. All level of care denials will be sent to the Mental Health Services Bureau for review. Assessment of the contract agency's performance is part of the quality assurance process.

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Disseminate information concerning the waiver to potential enrollees	✓	☐	✓	☐
Assist individuals in waiver enrollment	✓	☐	✓	☐
Manage waiver enrollment against approved limits	✓	☐	✓	☐
Monitor waiver expenditures against approved levels	✓	☐	✓	☐
Conduct level of care evaluation activities	✓	☐	✓	☐
Review participant service plans to ensure that waiver requirements are met	✓	☐	✓	☐
Perform prior authorization of waiver services	✓	☐	✓	☐
Conduct utilization management functions	✓	☐	✓	☐
Recruit providers	✓	☐	✓	☐
Execute the Medicaid provider agreement	✓	☐	✓	☐
Determine waiver payment amounts or rates	✓	☐	☐	☐
Conduct training and technical assistance concerning waiver requirements	✓	☐	☐	☐

Appendix B: Participant Access and Eligibility

Appendix B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Included	Target Group/Subgroup	Minimum Age	Maximum Age	
			Maximum Age Limit: Through age –	No Maximum Age Limit
○	**Aged or Disabled, or Both**			
☐	Aged (age 65 and older)			☐
☐	Disabled (Physical) (under age 65)			
☐	Disabled (Other) (under age 65)			
	Specific Aged/Disabled Subgroup			
☐	Brain Injury			☐
☐	HIV/AIDS			☐
☐	Medically Fragile			☐
☐	Technology Dependent			☐
○	**Mental Retardation or Developmental Disability, or Both**			
☐	Autism			☐
☐	Developmental Disability			☐
☐	Mental Retardation			☐
○	**Mental Illness**			
✓	Mental Illness (age 18 and older)	18		✓
☐	Serious Emotional Disturbance (under age 18)			

b. Additional Criteria. The State further specifies its target group(s) as follows:

"Severe disabling mental illness" means with respect to a person who is 18 or more years of age that the person meets the requirements of (a) or (b) or (c). The person must also meet the requirements of (d):

(a) has been involuntarily hospitalized for at least 30 consecutive days because of a mental disorder at Montana State Hospital at least once; or

(b) has a DSM-IV diagnosis of (i) schizophrenic disorder (295); (ii) other psychotic disorder (295.40, 295.70, 297.1, 297.3, 298.9, 293.81, 293.82); (iii) mood disorder (296.2x, 296.3x, 296.40, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89, 293.83); (iv) amnesic disorder (294.0, 294.8); (v) disorder due to a general medical condition (310.1); or (vi) pervasive developmental disorder not otherwise specified (299.80) when not accompanied by mental retardation; (vii) anxiety disorder (300.01, 300.21, 300.3) or

(c) has a DSM-IV diagnosis of personality disorder (301.00, 301.20, 301.22, 301.4, 301.50, 301.6,

301.81, 301.82, 301.83, or 301.90) which causes the person to be unable to work competitively on a full-time basis or to be unable to maintain a residence without assistance and support by family or a public agency for a period of at least 6 months (or for an obviously predictable period over 6 months); and

(d) has ongoing functioning difficulties because of the mental illness for a period of at least 6 months (or for an obviously predictable period over 6 months), as indicated by at least two of the following:

(i) medical professional with prescriptive authority has determined that medication is necessary to control the symptoms of mental illness;

(ii) the person is unable to work in a full-time competitive situation because of mental illness;

(iii) the person has been determined to be disabled due to mental illness by the Social Security Administration;

(iv) the person maintains a living arrangement only with the ongoing supervision , is homeless, or is at risk of homelessness due to mental illness; or

(iv) the person has had or will predictably have repeated episodes of decompensation. An episode of decompensation includes:
-increased symptoms of psychosis
-self-injury
-suicidal or homicidal intent, or
-psychiatric hospitalization.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one)*:

✓	Not applicable – There is no maximum age limit
○	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit (*specify*):

Appendix B-2: Individual Cost Limit

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*:

✓	**No Cost Limit**. The State does not apply an individual cost limit. *Do not complete Item B-2-b or Item B-2-c.*
○	**Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.* The limit specified by the State is *(select one)*:
	○ ____ %, a level higher than 100% of the institutional average
	○ Other *(specify)*:
○	**Institutional Cost Limit**. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
○	**Cost Limit Lower Than Institutional Costs**. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. *Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.*
	The cost limit specified by the State is *(select one)*:
	○ The following dollar amount: $ ____
	The dollar amount *(select one)*:
	○ Is adjusted each year that the waiver is in effect by applying the following formula:
	○ May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.
	○ The following percentage that is less than 100% of the institutional average: ____ %
	○ Other – *Specify:*

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

☐	The participant is referred to another waiver that can accommodate the individual's needs.
☐	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:
☐	Other safeguard(s) *(specify)*:

Appendix B-3: Number of Individuals Served

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	105
Year 2	125
Year 3	125
Year 4 (renewal only)	
Year 5 (renewal only)	

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

○	The State does not limit the number of participants that it serves at any point in time during a waiver year.
✓	The State limits the number of participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	105
Year 2	105
Year 3	105
Year 4 (renewal only)	
Year 5 (renewal only)	

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons

or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

✓	**Not applicable**. The state does not reserve capacity.
○	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:
	The capacity that the State reserves in each waiver year is specified in the following table:

Table B-3-c

Waiver Year	Purpose:	Purpose:
	Capacity Reserved	Capacity Reserved
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one):*

○	The waiver is not subject to a phase-in or a phase-out schedule.
✓	The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an ***intra-year*** limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity. *Select one:*

✓	Waiver capacity is allocated/managed on a statewide basis.
○	Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Individuals must:

- Be Medicaid eligible;
- Meet SDMI criteria;
- Be age 18 or older;
- Meet nursing facility level of care;
- Choose to receive waiver services; and
- Reside in an area within the state where the HCBS waiver is available and there's capacity within the waiver.

Entrance into the waiver will be on a first-come, first-served basis for those who meet the above-listed criteria. Once a waiting list has been established, the case management teams will use the Wait List Criteria Tool when an opening occurs. The Wait List Criteria Tool scores individuals eligible for the waiver according to criteria, including cognitive impairment, risk of medical deterioration without services, risk of institutional placement or death, need for supervision, need for formal paid services, assessment of informal supports, assessment of relief needed for primary caregiver, need for adaptive aides, and assessment of health and safety issue that place the individual at risk. The case managers will manage the waitlist, which will be submitted to a database at the Addictive and Mental Disorders Division of the Department of Public Health and Human Services.

Attachment #1 to Appendix B-3

Waiver Phase-In/Phase Out Schedule

a. The waiver is being *(select one)*:

✓	Phased-in
○	Phased-out

b. **Waiver Years Subject to Phase-In/Phase-Out Schedule** *(check each that applies)*:

Year One	Year Two	Year Three	Year Four	Your Five
✓	☐	☐	☐	☐

c. **Phase-In/Phase-Out Time Period**. *Complete the following table:*

	Month	Waiver Year
Waiver Year: First Calendar Month	October	
Phase-in/Phase out begins	October	WY1
Phase-in/Phase out ends	April	WY1

d. **Phase-In or Phase-Out Schedule**. *Complete the following table:*

Phase-In or Phase-Out Schedule			
	Waiver Year:		
Month	Base Number of Participants	Change in Number of Participants	Participant Limit
October	35		35
January	35		35
April	35		35

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

a. State Classification. The State is a *(select one)*:

✓	§1634 State
○	SSI Criteria State
○	209(b) State

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)				
☐	Low income families with children as provided in §1931 of the Act			
✓	SSI recipients			
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121			
☐	Optional State supplement recipients			
☐	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*			
	○	100% of the Federal poverty level (FPL)		
	○	%	of FPL, which is lower than 100% of FPL	
☐	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)			
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)			
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)			
☐	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)			
✓	Medically needy			
✓	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:			
	PICKLE, DAC			
Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*				
✓	**No**. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.			
○	**Yes**. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Select one and complete Appendix B-5.*			
	○	All individuals in the special home and community-based waiver group under 42 CFR §435.217		

○	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:				
	☐	A special income level equal to (select one):			
		○	300% of the SSI Federal Benefit Rate (FBR)		
		○	%	of FBR, which is lower than 300% (42 CFR §435.236)	
		○	$	which is lower than 300%	
	☐	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)			
	☐	Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)			
	☐	Medically needy without spend down in 209(b) States (42 CFR §435.330)			
	☐	Aged and disabled individuals who have income at: *(select one)*			
		○	100% of FPL		
		○	%	of FPL, which is lower than 100%	
	☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:			

Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one)*:

- ○ Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (*select one*):
  - ○ Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-b-2 (SSI State) or B-5-c-2 (209b State) and Item B-5-d.*
  - ○ Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). Do not complete Item B-5-d.*
- ○ Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. *Complete Item B-5-c-1 (SSI State) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

b-1. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ The following standard included under the State plan *(select one)*
  - ○ SSI standard
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The special income level for institutionalized persons *(select one):*
    - ○ 300% of the SSI Federal Benefit Rate (FBR)
    - ○ _____ % of the FBR, which is less than 300%
    - ○ $ _____ which is less than 300%.
  - ○ _____ % of the Federal poverty level
  - ○ Other (specify):
- ○ The following dollar amount: $ _____ If this amount changes, this item will be revised.

○	The following formula is used to determine the needs allowance:

ii. Allowance for the spouse only (*select one*):

○	SSI standard		
○	Optional State supplement standard		
○	Medically needy income standard		
○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Not applicable *(see instructions)*		

iii. Allowance for the family *(select one)*:

○	AFDC need standard		
○	Medically needy income standard		
○	The following dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Other (specify):		
○	Not applicable (see instructions)		

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

c-1. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ The following standard included under the State plan *(select one)*
  - ○ The following standard under 42 CFR §435.121:
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The special income level for institutionalized persons *(select one)*
    - ○ 300% of the SSI Federal Benefit Rate (FBR)
    - ○ % of the FBR, which is less than 300%
    - ○ $ which is less than 300% of the FBR
  - ○ % of the Federal poverty level
  - ○ Other (specify):
- ○ The following dollar amount: $ If this amount changes, this item will be revised.
- ○ The following formula is used to determine the needs allowance:

ii. Allowance for the spouse only (*select one*):

- ○ The following standard under 42 CFR §435.121
- ○ Optional State supplement standard
- ○ Medically needy income standard
- ○ The following dollar amount: $ If this amount changes, this item will be revised.
- ○ The amount is determined using the following formula:
- ❍ Not applicable *(see instructions)*

iii. Allowance for the family *(select one)*

- ○ AFDC need standard
- ○ Medically needy income standard

○	The following dollar amount: $ [ ] The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:
○	Other (specify):
○	Not applicable (see instructions)

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

NOTE: Items B-5-c-2 and B-5-d-2 are for use by states that use spousal impoverishment eligibility rules *and* elect to apply the spousal post eligibility rules.

b-2. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
○	The following standard included under the State plan *(select one)*			
	○	SSI standard		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The special income level for institutionalized persons *(select one):*		
		○	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300%.
	○	%		of the Federal poverty level
	○	Other (specify):		

○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The following formula is used to determine the needs allowance:		

ii. Allowance for the spouse only (*select one*):

○	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:		
	Specify the amount of the allowance:		
	○ SSI standard		
	○ Optional State supplement standard		
	○ Medically needy income standard		
	○ The following dollar amount:	$	If this amount changes, this item will be revised.
	○ The amount is determined using the following formula:		
✓	Not applicable		

iii. Allowance for the family *(select one)*:

○	AFDC need standard		
○	Medically needy income standard		
○	The following dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Other (specify):		
○	Not applicable (see instructions)		

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.

○	The State establishes the following reasonable limits *(specify)*:

c-2. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):

○	The following standard included under the State plan *(select one)*			
	○	The following standard under 42 CFR §435.121:		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The special income level for institutionalized persons *(select one)*		
		○	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300% of the FBR
	○	%	of the Federal poverty level	
	○	Other (specify):		
○	The following dollar amount:	$	If this amount changes, this item will be revised.	
○	The following formula is used to determine the needs allowance:			

ii. <u>Allowance for the spouse only</u> (*select one*):

○	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:			
	Specify the amount of the allowance:			
	○	The following standard under 42 CFR §435.121:		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The following dollar amount:	$	If this amount changes, this item will be revised.

	○	The amount is determined using the following formula:
○		Not applicable

iii. Allowance for the family *(select one)*

○	AFDC need standard
○	Medically needy income standard
○	The following dollar amount: $ _____ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:
○	Other (specify):
○	Not applicable (see instructions)

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care.

i. Allowance for the personal needs of the waiver participant *(select one)***:**

○	SSI Standard
○	Optional State Supplement standard
○	Medically Needy Income Standard
○	The special income level for institutionalized persons

○	%	of the Federal Poverty Level	
○	The following dollar amount:	$	If this amount changes, this item will be revised
○	The following formula is used to determine the needs allowance:		
○	Other (*specify*)**:**		

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. *Select one:*

○	Allowance is the same
○	Allowance is different. Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:

a. Health insurance premiums, deductibles and co-insurance charges.

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
○	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for waiver services:

i.	**Minimum number of services**. The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is *(insert number):*	
	Two	
ii.	**Frequency of services**. The State requires *(select one)*:	
	✓	The provision of waiver services at least monthly
	○	Monthly monitoring of the individual when services are furnished on a less than monthly basis. If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

○	Directly by the Medicaid agency
○	By the operating agency specified in Appendix A
✓	By an entity under contract with the Medicaid agency. *Specify the entity*:
	Mountain Pacific Quality Health Foundation
○	Other (*specify*):

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Registered Nurse or Licensed Practical Nurse; licensed in the State of Montana;

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The Mountain Pacific Quality Health Foundation will complete a PASARR Determination including a Functional Assessment to determine if the individual meets level of care requirements for enrollment into the waiver. Preadmission determination and functional assessment involves telephone interviews based on established protocols. A Level I screen will also be completed to determine if the individual has Mental Retardation or Mental Illness as part of PASARR requirements. Community Mental Health Centers will complete Level II screens to determine if an individual with Mental Illness identified through the Level I screen requires active treatment. Active treatment in Montana is provided by inpatient care at:

A) Local community hospitals with psychiatric units; or
B) The Montana State Hospital (MSH); or
C) Montana Mental Health Nursing Care Center (MMHNCC).

MSH and MMHNCC are Institutions for Mental Disease.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

✓	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
○	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation. Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

A level of care screening is performed to evaluate the medical, psychological and social needs of an individual. The Functional Assessment is a review of impairments in walking, bathing, grooming, dressing, toileting, transferring, feeding, bladder incontinence, bowel incontinence, special sense impairments (such as speech or hearing), mental and behavioral dysfunctions. Nursing facility or waiver level of care is authorized if the individual's needs are greater than personal level of care. The reevaluation process is the same.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

○	Every three months
○	Every six months
✓	Every twelve months
✓	Other schedule (*specify*):
	When there is significant change within the year.

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

✓	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
○	The qualifications are different. The qualifications of individuals who perform reevaluations are *(specify)*:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify)*:

The case Management Teams will use their own internal systems to track participants enrolled in the waiver and alert the Mountain Pacific Quality Health Foundation when a participant is due for a reevaluation of level of care. The quality assurance process will include a review by regional Community Program Officers to ensure the timeliness of reevaluation in accordance with quality assurance standards.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The Mountain Pacific Quality Health Foundation will maintain all evaluations and re-evaluations for a minimum of three years as required in 45 CFR §74.53.

Appendix B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

During the preadmission screening determination, the Mountain Pacific Quality Health Foundation will inform eligible individuals of the feasible alternatives available under the waiver and allow individuals to choose either institutional or waiver services, as long as the individuals reside in areas where the waiver is available (the SDMI Waiver will not be available statewide) and there is capacity.

b. Maintenance of Forms. Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The Mountain Pacific Quality Health Foundation will maintain the screening determination form, including all documentation regarding freedom of choice, for a minimum of three years.

Appendix B-8: Access to Services by Limited English Proficient Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The State will make reasonable accommodation upon request. Accommodations for foreign translators will be arranged through the local college and university system. Accommodations for consumers who are deaf or hearing impaired will be made through Montana Communications Access Program for the Deaf and Hard of Hearing Services. The State will utilize other resources including, but not limited to, the Special Needs Center through the Qwest phone book. Individuals are notified of the opportunity for reasonable accommodations in the Medicaid application process and in the Medicaid Screening determination letter.

Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Statutory Services *(check each that applies)*		
Service	Included	Alternate Service Title (if any)
Case Management	✓	
Chore	✓	
Homemaker	✓	
Home Health Aide	☐	
Personal Assistance Service and Specially Trained Attendant Care	✓	
Adult Day Health	✓	
Habilitation	✓	
Residential Habilitation	✓	
Day Habilitation	✓	
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	✓	
Supported Employment	✓	
Education	☐	
Respite	✓	
Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	✓	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	

Other Services *(select one)*	
○	Not applicable
✓	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:

a.	Adult Residential
b.	Chemical Dependency Counseling
c.	Dietitian/Nutrition/Meals
d.	Habilitation Aide
e.	Personal Emergency Response System
f.	Private Duty Nursing and Registered Nurse Supervision
g.	Specialized Medical Equipment and Supplies
h.	Supported Living
i.	Non-Medical Transportation
j.	Illness Management and Recovery
k.	Wellness Recovery Action Plan (WRAP)

Extended State Plan Services *(select one)*

○	Not applicable
✓	The following extended State plan services are provided *(list each extended State plan service by service title)*:
a.	Occupational Therapy
b.	Personal Assistance

Supports for Participant Direction *(select one)*

○	The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.
✓	Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	☐	
Financial Management Services	☐	

Other Supports for Participant Direction *(list each support by service title)*:

a.	
b.	
c.	

b. Alternate Provision of Case Management Services to Waiver Participants. When case management is not a covered waiver service, indicate how case management is furnished to waiver participants *(check each that applies)*:

☐	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*
☐	As an administrative activity. *Complete item C-1-c.*
☐	Not applicable – Case management is not furnished as a distinct activity to waiver participants. *Do not complete Item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C-2: General Service Specifications

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services *(select one)*:

○	**Yes**. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):
✓	**No**. Criminal history and/or background investigations are not required.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry *(select one)*:

○	**Yes**. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):
✓	**No**. The State does not conduct abuse registry screening.

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one*:

○	**No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete Items C-2-c.i – c.iii.*
✓	**Yes**. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Complete Items C-2-c.i –c.iii.*

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit
Assisted Living	Adult congregate residential care with 24 hours supervision and assistance with ADLs	Space dependent, no limit on number of individuals served
Group Home	Residential habilitation	Eight or less
Adult Foster Care	Light personal care and custodial care	Space dependent

Adult Day	Restorative assistance with ADLs	Space dependent
Retirement Homes	Congregate meals or central kitchen. No personal assistance with ADLs	Space dependent

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

A home-like character is maintained in larger facilities through measures such as: being located in the community, allowances to bring in personal belongings and decorations of living space, providing access to resources and activities in the community, providing choice and selection of home-cooked meals, providing access to cooking facilities, providing for individual differences in schedules and providing privacy.

iii. Scope of Facility Standards. By type of facility listed in Item C-2-c-i, specify whether the State's standards address the following *(check each that applies)*:

Standard	Facility Type: Assisted Living	Facility Type: Group Home	Facility Type: Adult Foster Home	Facility Type: Adult Day	Facility Type: Retirement Home	Facility Type: Area Agency on Aging
Admission policies	✓	✓	✓	✓	✓	✓
Physical environment	✓	✓	✓	✓	✓	✓
Sanitation	✓	✓	✓	✓	✓	✓
Safety	✓	✓	✓	✓	✓	✓
Staff : resident ratios	○	○	○	○	○	○
Staff training and qualifications	✓	✓	✓	○	○	○
Staff supervision	✓	✓	✓	✓	✓	○
Resident rights	✓	✓	✓	✓	✓	✓
Medication administration	✓	✓	✓	○	○	○
Use of restrictive interventions	✓	✓	✓	○	○	○
Incident reporting	✓	✓	✓	○	○	○
Provision of or arrangement for necessary health services	✓	✓	✓	○	○	○

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

All standards are based on licensure requirements in accordance with the Administrative Rules of Montana. Those not checked do not apply to the type of facility listed and are therefore not reviewed by the Licensing Bureau, Quality Assurance Division, Department of Public Health and Human Services, as part of their compliance reviews. Facilities are inspected to ensure adherence to those requirements which are checked above. Staff ratios are not addressed in the state regulations other than to indicate a need for sufficient staff to meet consumer needs. Services to waiver consumers are routinely monitored by Case Management Teams who ensure health and safety of waiver recipients in the facilities.

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

✓	**No**. The State does not make payment to legally responsible individuals for furnishing personal care or similar services. (UNDER THE SDMI WAIVER)
○	**Yes**. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

✓	The State does not make payment to relatives/legal guardians for furnishing waiver services.
○	The State makes payment to relatives/legal guardians under ***specific circumstances*** and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
○	Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*

○	Other policy. *Specify*:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

All potential SDMI waiver providers may become Medicaid providers as long as they meet the provider qualifications and reside in the area in the state where the SDMI waiver is available. Providers meeting all the provider requirements may enroll as Medicaid providers. All requests for enrollment in the Medicaid Program must be made through the State's fiscal intermediary, Affiliated Computer Systems (ACS). ACS will provide interested providers with enrollment information. The enrollment application must be completed in its entirety before ACS is able to process the enrollment application. ACS will forward all completed enrollment applications to the Addictive and Mental Disorders Division, Department of Public Health and Human Services, for approval, procedure codes and rates.

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Case Management

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Case Management entails:
Development and review of the plan of care with the consumer
Reevaluation of the plan of care including a functional assessment and appropriateness of services in the care plan
Coordination of services
Linking consumers to other programs
Monitoring implementation of service plan
Ensuring health and safety
Addressing problems with respect to services and providers
Responding to crises
Being financially accountable for waiver expenditures for consumers on the waiver

Case management assists consumers in gaining access to needed Home and Community Based Services and other State Plan services as well as needed medical, social, educational and other services regardless of the funding source.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Case Management Provider Agencies

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Case Management			Administrative Rules of Montana; Proposed Rule IX;

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Medicaid Enrolled Providers	Department of Public Health and Human Services	Upon Enrollment and Annually

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Service Specification	
Service Title:	Chore

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Chore services are provided to consumers unable to manage their own homes.

Chore activities include extensive cleaning beyond the scope of general household cleaning under the waiver service, Homemaker Services. Chore services may include but are not limited to heavy cleaning; washing windows or walls; yard care; walkway maintenance; minor home repairs; wood chopping and stacking.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services shall be provided only after other homemaker services through any other entity have been exhausted.

Chore services are not allowed for a consumer residing in an adult residential setting.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Home Health Agency
				Personal Assistance Service (PAS) Provider
				Homemaker Provider

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Health Agency		Medicare Certified	Administrative Rules of Montana Proposed Rule XVI
PAS Provider			Administrative Rules of Montana Proposed Rules XVI and XV
Homemaker Provider			Administrative Rules of Montana Proposed Rule XVI

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health Agency	Department of Public Health and Human Services	Upon Enrollment & Annually

PAS Provider	Department of Public Health and Human Services	Upon Enrollment & Annually
Homemaker Provider	Department of Public Health and Human Services	Upon Enrollment & Annually

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Service Specification	
Service Title:	Homemaker

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Homemaker services consist of general household activities. Homemaker services are provided to consumers unable to manage their own homes. Homemaker services do not include personal care services available under State Plan Medicaid.

Homemaker activities include tasks related to household management. This may include assisting the consumer to find and relocate to other housing, assisting consumer with boxing, unpacking and organizing household items. In addition the service provides general housecleaning and meal preparation, as well as teaching services that improve a consumer or family's skills in household management and social functioning.

Social restorative services include activities that will further a consumer's involvement with activities and other persons. This may include reimbursement to the homemaker for escort to social functions if the consumer's needs require such a service. Social restorative services under Homemaker are different from Socialization under Home and Community Based Services Personal Assistance Service (HCBS PAS). Social restorative services under Homemaker are intended for those consumers who **do not** require assistance with personal care. If a consumer can use homemaker services, HCBS PAS should not be utilized.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services shall be provided only after other homemaker services through any other entity have been exhausted.

Homemaker services are not allowed for a consumer residing in an adult residential setting.

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Home Health Agency
				Personal Assistance Services (PAS) Provider
				Homemaker Provider

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Health Agency		Medicare Certified	Administrative Rules of Montana Proposed Rule XVI
PAS Provider			Administrative Rules of Montana Proposed Rules XVI and XV
Homemaker Provider			Administrative Rules of Montana Proposed Rule XVI

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health Agency	Department of Public Health and Human Services	Upon Enrollment & Annually
PAS Provider	Department of Public Health and Human Services	Upon Enrollment & Annually
Homemaker Provider	Department of Public Health and Human Services	Upon Enrollment & Annually

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Service Specification

Service Title:	Personal Assistance

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Personal assistance services under the Home and Community Based Services (HCBS) Program may include supervision for health and safety reasons, socialization, escort and transportation for non-medical reasons, specially trained attendants for consumers with mental health needs, or an extension of State Plan personal assistance services. Socialization under personal assistance is different from social restorative services under homemaker services. Socialization is available to those consumers who **require** personal assistance to access the community, rather than just assistance with the access (social restorative).

Specially trained personal assistance services are provided by attendants who have been specially trained to meet the unique needs of the HCBS consumer. It is the responsibility of the provider agency to ensure that assistants are appropriately trained under agency based services. Areas of special training include knowledge and understanding of serious mental illness and the needs of consumers with mental illness.

Senior and Long Term Care Division, Department of Public Health and Human Services, has developed a manual for personal assistance provider agencies that outlines all policies and procedures relating to the Personal Assistance Services Program. This manual should be referred to for policy information.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services provided under the waiver exceed or differ in scope from those available under the State Plan. State Plan services must be accessed first.

Personal assistance services are not allowed for a consumer residing in adult residential setting.

Services under this definition are not duplicative of the transportation service.

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Personal Assistance Service (PAS) Providers
				Home Health Agencies

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
PAS Provider			Administrative Rules of Montana Proposed Rules XV and XIII
Home Health Agency		Medicare Certified	Administrative Rules of Montana Proposed Rules XV and XIII

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
PAS Provider	Department of Public Health and Human Services	Upon enrollment and Annually
Home Health Agency	Department of Public Health and Human Services	Upon enrollment and Annually

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Service Specification	
Service Title:	Adult Day Health

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Adult Day Health provides a broad range of health, nutritional, recreational, and social and habilitation services in licensed settings outside the person's place of residence. Adult Day Health services do not include residential overnight services. Adult day health services are furnished in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the consumer. Meals provided as part of these services will not constitute a "full nutritional regiment" (3 meals per day). The scope of Adult Day Health service will not duplicate State Plan services or habilitation aid services. Transportation between the consumer's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is not duplicative of the transportation service, or the meals provided under the distinct meals service.				
Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Adult Day Health Provider
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Adult Day Health Provider	Licensed as an Adult Day Center (Administrative Rules of Montana 37.106.301, et seq.)		Administrative Rules of Montana Proposed Rule XII

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Adult Day Health Provider	Department of Public Health and Human Services	Upon Enrollment and Annually

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Service Specification Service Specification

Service Title:	Residential Habilitation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Residential Habilitation is provided in a licensed group home. Residential Habilitation is a bundled service that includes habilitation to meet the specific needs of each resident; homemaker services; medication oversight; social activities; personal care; recreational activities at least twice a week, transportation; medical escort; and 24-hour on-site awake staff to meet the needs of the residents and provide supervision for safety and security.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Medicaid reimbursement for room and board is prohibited so the consumer must pay room and board costs.

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Group Home
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Group Home	Group Home License		Administrative Rules of Montana Proposed Rule X

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Group Home	Department of Public Health and Human Services	Upon Enrollment and Annually

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Service Specification

Service Title:	Day Habilitation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Day Habilitation is assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills, which take place in a non-residential setting, separate from the home or facility in which the consumer resides. Services shall normally be furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, unless provided as an adjunct to other day activities included in the consumer's plan of care.

Day Habilitation services shall focus on enabling the individual to attain his or her maximum functional level, and shall be coordinated with any therapies listed in the plan of care. In addition, Day Habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

Providers of Day Habilitation must be licensed as an adult day care provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Reimbursed for meals is limited to two a day. This service is not duplicative of the transportation service or the meals under the distinct meals service.

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Supported Living Provider

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Supported Living Provider			Administrative Rules of Montana Proposed Rule XI

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Supported Living Provider	Department of Public Health and Human Services	Upon Enrollment and Annually

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Service Specification	
Service Title:	Prevocational Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Prevocational Services are habilitative activities that foster employability for a HCBS consumer. Prevocational Services:

Are aimed at preparing an individual for paid or unpaid employment;

Include teaching such concepts as compliance, attendance, task completion, problem solving, endurance, work speed, work accuracy, attention span, motor skills and safety; and

Are provided to persons who may or may not join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

When compensated, consumers are paid at less than 50 percent of the minimum wage. Activities included in this service are generally not directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the consumer's plan of care.

Must not be provided if they are available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Education of the Handicapped Act. The Case Management Team must document in the file of each individual receiving this service that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973 or P.L. 94-142. This documentation may be obtained from the Rehabilitation Services Program, Department of Public Health and Human Services;

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Supported Living Provider

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Supported Living Provider			Administrative Rules of Montana Proposed Rule XIV

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Supported Living Provider	Department of Public Health and Human Services	Upon Enrollment and Annually

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Service Specification	
Service Title:	Supported Employment

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Supported employment includes activities needed to sustain paid work by consumers, including supervision and training for persons for whom unsupported or competitive employment at or above the minimum wage is unlikely. Supported employment is conducted in a variety of settings. Supported employment may include group community employment such as crews, enclaves or individual community employment.

When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by consumers as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting by the employer or for items the employer is required to provide under the Americans with Disabilities Act.

Supported employment services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973, or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973 or P.L. 94-142. This documentation may be obtained from with the Rehabilitation Services Program, Department of Public Health and Human Services.

Transportation may be provided between the consumer's place of residence and the job site or between job sites (in cases where the consumer is working in more than one place) as a component of supported employment services.

Use of community transportation, including specialized transportation is encouraged.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is not duplicative of the transportation service.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Supported Living Provider
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate	Other Standard *(specify)*

		(specify)	
Supported Living Provider			Administrative Rules of Montana Proposed Rule XI

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Supported Living Provider	Department of Public Health and Human Services	Upon enrollment and Annually

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Service Specification	
Service Title:	Respite

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Respite care is temporary, short-term care provided to consumers in need of supportive care to relieve those persons who normally provide the care. Respite care is only utilized to relieve a non-paid caregiver. Respite care may include payment for room and board in adult residential facilities, nursing homes, or group homes.

Respite care can be provided in the consumer's residence or by placing the consumer in another private residence, adult residential setting or other community setting, group home, or licensed nursing facility.

When respite care is provided, the provision of, or payment for other duplicative services under the waiver is precluded (e.g., payment for respite when consumer is in Adult Day Care).

If a consumer requires assistance with activities of daily living during the respite hours, a personal assistant should be used under State Plan or Home and Community Based Services Personal Assistance Services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	✓	Agency. List the types of agencies:
				PAS Provider
				Homemaker Services Provider
				Nursing Facility
				Adult Residential Facility
				Foster Care

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Party	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
PAS Provider			Administrative Rules of Montana Proposed Rule XVII
Homemaker Providers			Administrative Rules of Montana Proposed Rule XVII
Nursing Facility	Licensed in the State of Montana		Administrative Rules of Montana Proposed Rule XVII
Adult Residential Facility	Licensed in the State of Montana		Administrative Rules of Montana Proposed Rule XVII
Foster Care	Licensed in the State of Montana		Administrative Rules of Montana Proposed Rule XVII

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	PAS/Homemaker Agency	Department of Public Health and Human Services	Upon Enrollment and Annually
	Nursing Facility	Department of Public Health and Human Services	Upon enrollment and Annually
	Adult Residential Facility	Department of Public Health and Human Services	Upon enrollment and Annually
	Foster Care	Department of Public Health and Human Services	Upon enrollment and Annually

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Service Specification	
Service Title:	Psychosocial Rehabilitation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Psychosocial Rehabilitation services are those services provided by a licensed mental health professional, which are within the scope of practice of the profession. Mental health services are limited to those allowed under 37-17-102(5), MCA. A licensed mental health professional is a licensed clinical psychologist, licensed clinical social worker or licensed professional counselor.

HCBS Psychosocial Rehabilitation services include:

1) counseling for the HCBS consumer after the consumer's State Plan limits have been exhausted; and

2) consultation with providers and caregivers directly involved with the consumer for the development and monitoring of behavior programs.

Psychosocial rehabilitation services are in addition to the limits of the State Plan program.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Mental health professional services under the State Plan will be utilized prior to any waiver services.
Extended Psychosocial Rehabilitation services do not include Illness Management and Recovery services.

Provider Specifications

Provider Category(s) *(check one or both)*:	✓	Individual. List types:	✓	Agency. List the types of agencies:
		Mental Health Professionals		Licensed Mental Health Centers

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
MH Professionals	Licensed Counselor, Licensed Social Worker, Therapists, Psychologists		Administrative Rules of Montana Proposed Rule XIX
Licensed Mental Health Centers	Licensed as a Mental Health Center		Administrative Rules of Montana Proposed Rule XIX

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Licensed Mental Health Professional	Department of Public Health and Human Services	Upon Enrollment and Annually
	Licensed Mental Health Center	Department of Public Health and Human Services	Upon Enrollment and Annually

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Service Specification

Service Title:	Adult Residential Care

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Adult Residential Care is provided in an Adult Foster Home (AFH) OR Assisted Living Facility (ALF). Case Management Teams (CMTs) will have a fixed number of slots for this service.

Covered Services:

Adult Residential is a bundled service which includes personal care, homemaker services, nutritional meals and snacks, medication oversight (to the extent permitted under state law), social and recreational activities and 24-hour onsite response to ensure that the care, well being, health and safety needs of the residents are met at all times.

The Department of Public Health and Human Services must license adult foster homes and assisted living facilities. HCBS consumers in these facilities cannot have needs which are beyond the scope of the provider's license. CMT records must include the signed resident agreement for consumers in Assisted Living Facilities.

Adult Foster Homes

Pursuant to the rules governing these facilities, residents should require only light personal care and cannot have more than 30 consecutive days of skilled nursing visits, not to exceed two hours a day. The latter does not include setting up medications even if a nurse performs this task. It may be acceptable for an individual to receive nursing services in excess of the limit if they are not consecutive **and** if the resident's condition, which requires nursing, is not chronic. An individual who cannot self-administer medications is not appropriate for an adult foster home. It is the responsibility of the facility to monitor the number of nursing visits.

Assisted Living Facilities 'A' Bed

In accordance with the Administrative Rules of Montana, an individual in an 'A' bed is limited to skilled nursing care or other skilled services related to temporary, short-term acute illness, which may not exceed 30 consecutive days for one episode or more that 120 days total in one year. If the resident or the resident's family contracts for the nursing, it is not included in the limit, i.e., third party providers not contracting with the facility can provide nursing for longer than **30** consecutive days. It is the responsibility of the facility to monitor the number of nursing visits. For waiver recipients the limit is noted in the consumers' service plan and falls under the classification of third party provider.

Assisted Living Facilities 'B' Bed

A resident of a 'B' bed can receive any skilled services that would be available in a nursing home as long as the facility meets all the conditions outlined in the licensure rule.

Assisted Living Facilities 'C' Bed

A category 'C' facility refers to an assisted living that has a secure distinct part or locked unit that is designated for the exclusive use of residents with severe cognitive impairment. Severe cognitive impairment means the loss of intellectual functions, such as thinking, remembering and reasoning, of sufficient severity to interfere with a person's daily functioning. Such a person is incapable of recognizing danger, self-evacuating, summoning assistance, expressing need and/or making basic care decisions.

Medicaid reimbursement for room and board is prohibited. The provider cannot bill Medicaid for services on days the consumer is absent from the facility. If the consumer is transferring from one adult residential care setting to another, the discharging facility may not bill on day of transfer. Consumers in adult residential care may not receive the following services under the HCBS program:

1. Personal Assistance;
2. Homemaking;
3. Environmental Modifications;
4. Personal Emergency Response System;
5. Respite; or
6. Meals.

These restrictions apply only when HCBS payment is being made for the adult residential service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Assisted Living Facility
				Adult Foster Home
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Assisted Living Facility	Assisted Living Facility		Administrative Rules of Montana Proposed Rule X
Adult Foster Home	Licensed Foster Home		Administrative Rules of Montana Proposed Rule X

Verification of Provider Qualification	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Assisted Living Facility	Department of Public Health and Human Services	Upon Enrollment and Annually
	Adult Foster Home	Department of Public Health and Human Services	Upon Enrollment and Annually

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Service Specification	
Service Title:	Chemical Dependency Counseling

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Services that provide individual and/or group counseling in an outpatient setting for consumers who have a substance abuse problem to meet the goals set forth in the consumer's service and support plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)*:	✓	Individual. List types:	✓	Agency. List the types of agencies:
		Chemical Dependency Counselor		Counseling Services Provider
		Licensed Addictive Counselor		
Specify whether the service may be	☐	Legally Responsible Person	☐	Relative/Legal Guardian

provided by *(check each that applies):*				

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual		Certification by the Department of Public Health and Human Services	Administrative Rules of Montana Proposed Rule XX
Medicaid Enrolled Provider		Certification by the Department of Public Health and Human Services	Administrative Rules of Montana Proposed Rule XX

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Individual/Agency	Department of Public Health and Human Services	Upon Enrollment and Annually

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Service Specification

Service Title:	Dietitian/Nutrition /Meals

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Services which consist of the provision of hot or other appropriate meals once or twice a day, up to seven days a week. In keeping with the exclusion of room and board as covered services, a full nutritional regimen of three meals per day will not be provided. In addition, nutrition/dietician consists of education and meal planning services provided by a registered dietitian or a licensed nutritionist for consumers who have medically restricted diets or for consumers who do not eat appropriately to maintain health.

Dietitian Services mean services related to the management of a recipient's nutritional needs and include the following: evaluation and monitoring of nutritional status; nutrition counseling; therapy; and education and research.

Dietitian services must be provided by a registered dietitian or a licensed nutritionist. Registered dietitians must meet the qualifications in 37-21-302 MCA and licensed nutritionists must meet the licensing requirements in 37-25-302, MCA.

Nutrition services include the provision of meals in a congregate setting or home-delivered meals. Nutrition services can also include, but are not limited to, meals from restaurants, hospitals and meal service in a residential setting that is not considered room and board (e.g. apartment that offers meal service separate from room and board).

Congregate or home delivered meals must be provided as defined in Administrative Rules of Montana Proposed Rule XXII.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

No more than two meals a day shall be provided to consumers through congregate or home-delivered meals. Providing more than two meals a day constitutes a full nutritional regimen or "board", which is not reimbursable under the Home and Community Based Services Program.

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List:	✓	Agency. List the types of agencies:
				Area Agency on Aging
				Restaurants
				Retirement Homes

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual	37-21-302, MCA 37-25-302, MCA		Administrative Rules of Montana Proposed Rules XXI and XXII
Provider Agencies			Administrative Rules of Montana Proposed Rules XXI and XXII

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Provider Agency / Individual	Department of Public Health and Human Services	Upon Enrollment and Annually

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Service Specification

Service Title:	Habilitation Aide

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Habilitation aide provides assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills, which takes place in a non-residential setting, separate from the home or facility in which the consumer resides. Habilitation aides must be physically and mentally able to perform the duties required and able to follow written orders. The habilitation aide is utilized when imparting a skill unto a consumer whereas a personal assistance may perform the task for the consumer. The consumer and the Case Management Team will evaluate when to utilize the services of the habilitation aide.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Supported Living Provider
				PAS Provider
Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Supported Living Provider			Administrative Rules of Montana Proposed Rule XIV
PAS Provider			Administrative Rules of Montana Proposed Rules XIV, XII and XV

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Supported Living Provider	Department of Public Health and Human Services	Upon Enrollment and Annually
	PAS Provider	Department of Public Health and Human Services	Upon Enrollment and Annually

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Service Specification	
Service Title:	Personal Emergency Response System (PERS)

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope):

Personal Emergency Response System (PERS) is an electronic device which enables a consumer to secure help in the event of an emergency. The consumer may choose to wear a portable "help" button to allow for increased independence and mobility. The system is connected to the consumer's phone and is programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. PERS services are limited to those consumers who live alone, or who are alone for significant parts of the day, and have no regular caretaker for extended periods of time, and who would otherwise require extensive routine supervision.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Local Emergency Response

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Emergency Response Provider			Administrative Rules of Montana proposed Rule XXIV

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	PERS Provider	Department of Public Health and Human Services	Upon Enrollment and Annually

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Service Specification

Service Title:	Private Duty Nursing

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Private Duty Nursing Services are services provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) licensed to practice in Montana. These services are provided to a consumer at home. Private duty nursing services are medically necessary services provided to consumers who require continuous in-home nursing care that is not available from a home health agency. Private duty nursing service provided by an LPN must be supervised by an RN, physician, dentist, osteopath or podiatrist authorized by State law to prescribe medication and treatment. Private Duty Nursing may be prescribed only when Home Health Agency Services, as provided in ARM 37.40.701, are not appropriate or available and must comply with the Montana Nurse Practice Act. Services are provided according to the consumer's service and support plan, which documents the consumer's specific health-related need for nursing. Use of a nurse to routinely check skin condition, review medication use or perform other nursing duties in the absence of a specific identified problem, is not allowable. General statements such a "monitor health needs" are not considered sufficient documentation for the service. Private duty nursing is not a state plan service for adults.

RN Supervision is a service that provides supervision of an LPN who renders private duty nursing services under the Home and Community Based Services program.

RN Supervision services must be provided by a registered nurse who meets the licensure and certification requirements provided in ARM 8.32.401.

The registered nurse can be from a home health agency or an independent agency. The consumer and the case management team will have input in the amount and degree of supervision required and the projected cost.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications					
Provider Category(s) *(check one or both)*:	✓	Individual. List types:	✓	Agency. List the types of agencies:	
		Licensed Registered Nurse		Home Health Agency	
		Licensed Practical Nurse		Private Duty Nursing Agency	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian	

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Health Agency or Private Duty Nursing Agency	Registered Nurse or Licensed Practical Nurse according to ARM 8.32.401 et. Seq.		Administrative Rules of Montana Proposed Rule XXIII
Individual	Registered Nurse or Licensed Practical Nurse according to ARM 8.32.401 et. Seq.		Administrative Rules of Montana Proposed Rule XXIII

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Home Health Agency or Private Duty Nursing Agency	Department of Public Health and Human Services	Upon enrollment and Annually
	Individual	Department of Public Health and Human Services	Upon enrollment and Annually

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Service Specification	
Service Title:	Specialized Medical Equipment and Supplies

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.

○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Specialized medical equipment and supplies include devices, controls, or appliances, specified in the service and care plan, which enable consumers to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Specialized medical equipment and supplies include the provision of adapted vans and service animals as well as items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the state plan and shall exclude those items that are not of direct medical or remedial benefit to the consumer. All items shall meet applicable standards of manufacture, design and installation.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Specialized Medical Equipment and Supplies will be limited to a one-time purchase with the exception of supplies not covered by State plan services. The Addictive and Mental Disorders Division, at its discretion, may authorize an exception to this. Purchases in excess of $5,000 must receive prior authorization from the Community Program Officer.

Specialized Medical Equipment and Supplies will not pay for vehicles, vehicle licenses or insurance.

Any equipment or supply covered under the State Plan must be used prior to the waiver.

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐ Individual. List types:	✓ Agency. List the types of agencies:
		DME Providers or other retailers

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Durable Medical Equipment Providers/Retailers			All services are provided in accordance with applicable Federal, State or local building codes and requirements (i.e., obtain permits), meet applicable standards of manufacture, design and installed requirements (i.e., obtaining permits) and comply with Administrative Rules of Montana Proposed Rule XXVI.

	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Verification of Provider Qualifications	Durable Medical Equipment Provider/Retailers	Department of Public Health and Human Services	State during permit process; Upon Enrollment and Annually

Service Delivery Method

Service Delivery Method	☐	Participant-directed as specified in Appendix E	✓	Provider managed

(check each that applies):				

Service Specification	
Service Title:	Supported Living

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Supported Living is the provision of supportive services to a consumer residing in an individual residence or in a group living situation.

Supported Living is a bundled service which includes: independent living evaluation, homemaking, habilitation aides, non-medical transportation, specially trained attendants, prevocational training, supported employment, 24-hour availability of staff for supervision and safety, and service coordination to coordinate supported living services.

Supported Living providers must have two years experience in providing the following services to persons with mental illness: integrated living; congregate living; personal social and community services; community employment services; and work services.

Consumers of this service must have identifiable Home and Community Based Services goals that are reviewed by the Case Management Team every 6 months or more frequently if necessary. Supported Living providers must show progress in the achievement of these goals.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

There will be no duplicative payments for homemaking, habilitation aide, non-medical transportation, specially trained attendants, prevocational training, or supported employment.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Supported Living Provider

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Supported Living Provider			Administrative Rules of Montana Proposed Rule XI

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Supported Living Provider	Department of Public Health and Human Services	Upon Enrollment and Annually

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Service Specification

Service Title:	Non-Medical Transportation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Transportation means travel furnished by common carrier or private vehicle for non-medical reasons as defined in the individual plan of care. Medical transportation is available under the State Plan Medicaid Program.
Transportation Services must meet the following criteria:

Be provided only after volunteer, state plan or other publicly funded transportation programs have been exhausted or determined to be inappropriate; and

Be provided by the most cost effective mode;

Transportation providers must provide proof of:

A valid Montana driver's license;
Adequate automobile insurance; and
Assurance that vehicle is in compliance with all applicable federal, state and local laws and regulations.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) *(check one or both)***:**	✓	Individual. List types:	✓	Agency. List the types of agencies:
		Taxi Cabs		Personal Assistance Service (PAS) Providers
				Accessible Transportation Providers
				Private Ambulance Service Providers
				Hospital Ambulance Service Providers

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Taxi Cabs	Must meet all pertinent state laws and regulations		Administrative rules of Montana Proposed Rule XXVI
PAS Providers			Administrative rules of Montana Proposed Rule XXVI
Accessible Transportation Providers	Must meet all pertinent state laws and regulations		Administrative rules of Montana Proposed Rule XXVI
Private Ambulance	Must meet all		Administrative rules of Montana Proposed

Service Providers and Hospital Ambulance Service Providers	pertinent state laws and regulations		Rule XXVI

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Taxi Cabs	Department of Public Health and Human Services	As Required by Law; Upon Enrollment and Annually
	PAS Providers	Department of Public Health and Human Services	Upon Enrollment and Annually
	Accessible Transportation Providers	State	As Required by Law; Upon Enrollment and Annually
	Private Ambulance Service Providers and Hospital Ambulance Service Providers	State	As Required by Law; Upon Enrollment and Annually

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Service Specification

Service Title:	Extended State Plan - Occupational Therapy Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Extended state plan occupation therapy services provided when the limits of Occupational Therapy Services under the approved State plan are exhausted. The scope and nature of these services do not otherwise differ from Occupational Therapy Services furnished under the State plan, except that palliative therapies are allowed. The provider qualifications specified in the State plan apply.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

State Plan Occupational Therapy Services will be utilized prior to HCBS.

Provider Specifications

Provider Category(s) *(check one or both)***:**	✓	Individual. List types.	✓	Agency. List the types of agencies:
		Licensed Occupational Therapist		Hospital
				Home Health Agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Individual Occupational Therapist	As required by Montana law and regulations		Administrative Rules of Montana Proposed Rule XVIII
Hospital / Home Health Agency	As required by Montana law and regulations		Administrative Rules of Montana Proposed Rule XVIII

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Individual	Department of Public Health and Human Services	Upon Enrollment and Annually
	Agency (Hospital or Home Health Agency)	Department of Public Health and Human Services	Upon Enrollment and Annually

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Service Specification

Service Title:	Illness Management and Recovery

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Illness Management and Recovery Program consists of a series of weekly sessions where licensed mental health practitioners help a consumer develop a personalized strategy for managing mental illness and achieving personal goals. The program can be provided in an individual or group format and generally lasts for three to six months. It is designed for individuals who have experienced the symptoms of schizophrenia, bipolar disorder and major depression. In the sessions, practitioners work collaboratively with individuals, offering a variety of information, strategies and skills that individuals can use to further their own recovery. There is a strong emphasis on helping individuals set and pursue personal goals and helping them put strategies into action in their everyday lives. Illness Management and Recovery has been identified as an evidence-based practice the Substance Abuse and Mental Health Services Administration.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) *(check one or both)***:**	✓	Individual. List types:	✓	Agency. List the types of agencies:
		Licensed Mental Health Professionals		Licensed Mental Health Centers

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Licensed Mental	As required by		Administrative Rules of Montana Proposed

Health Professionals	Montana law and regulations		Rule XXVII
Licensed Mental Health Centers	As required by Montana law and regulations		Administrative Rules of Montana Proposed Rule XXVII

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Licensed Mental Health Professionals	Department of Public Health and Human Services	Upon Enrollment and Annually
	Licensed Mental Health Centers	Department of Public Health and Human Services	Upon Enrollment and Annually

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Service Specification

Service Title:	Wellness Recovery Action Plan (WRAP)

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Wellness Recovery Action Plan (WRAP) is a self-management and recovery program. WRAP is designed to decrease and prevent intrusive or troubling feelings and behaviors, increase personal empowerment, improve quality of life and assist consumers in achieving their own life goals.

The Case Management Team (CMT) will require a provider of WRAP services to be certified by the Copeland Center. The CMT must authorize reimbursement for costs associated with attending the training.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Copeland Center

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Copeland Center			Administrative Rules of Montana Proposed Rule XXVIII

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Copeland Center	Department of Public Health and Human Services	Upon Enrollment and Annually

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(check each that applies).*

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; and, (f) how participants are notified of the amount of the limit.

☐	**Limit(s) on Set(s) of Services**. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. *Furnish the information specified above.*
☐	**Prospective Individual Budget Amount**. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. *Furnish the information specified above.*
☐	**Budget Limits by Level of Support**. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above.*
☐	**Other Type of Limit.** The State employs another type of limit. *Describe the limit and furnish the information specified above.*
✓	**Not applicable.** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	SDMI Waiver

a. **Responsibility for Service Plan Development**. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(check each that applies)*:

☐	Registered nurse, licensed to practice in the State
☐	Licensed practical or vocational nurse, acting within the scope of practice under State law
☐	Licensed physician (M.D. or D.O)
✓	Case Manager (qualifications specified in Appendix C-3)
☐	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
☐	Social Worker. *Specify qualifications:*
☐	Other (*specify the individuals and their qualifications):*

b. Service Plan Development Safeguards. *Select one:*

○	Entities and/or individuals that have responsibility for service plan development *may not provide* other direct waiver services to the participant.
✓	Entities and/or individuals that have responsibility for service plan development *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:
	Affirmation of administrative separateness between the case management team services and the other services provided by the case management agency.

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Consumers will develop the plan of care with their Case Management Team (CMT). Family, friends, and anyone of the consumers' choosing may support the consumer during the plan of care development. The CMT will maximize the extent to which a consumer participates by explaining the consumer-centered planning process; assisting the consumer to explore and identify his/her preferences, desired outcomes, goals, and the services and supports that will assist him/her in achieving desired outcomes; identifying and reviewing with the consumer issues to be discussed

during the planning process; and giving each consumer an opportunity to determine the location and time of planning meetings, participants attending the meetings, and frequency and length of the meetings. The consumer will have the authority to determine who is included in the process of service and support plan development. The consumer signs off on the service and support plan once it is completed.

d. Service Plan Development Process In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) A plan of care is a written plan developed by the consumer and the Case Management Team (CMT) to assess the consumer's status and needs. The plan of care outlines the services that will be provided to the consumer to meet his/her identified needs as well as the cost of those services. An initial plan of care must be developed prior to the person's enrollment. The initial enrollment date is the date the consumer begins receiving services under the Home and Community Based Services Waiver. This date will be entered in the upper left corner of the Plan of Care form and will be entered into the case notes. The CMT will notify Eligibility Staff of the Department of Public Health and Human Services (Department) whenever a Medicaid consumer is being admitted in the HCBS Waiver Program. The consumer must sign the plan of care. The Community Program Officer (CPO) must approve the initial plan of care.

(b)(c) The CMT will use an assessment tool to record the consumer's strengths, capacities, needs, preferences and desired outcomes along with his/her health status and risk factors. As needed, the CMT will consult with the consumer and/or the consumer's representative and other health care professionals. The CMT may also consult family members, relatives, psychologists, medical personnel and other consultants as necessary, with the consumer's approval. The plan of care development includes the consumer's choice of providers. This will be accomplished by the CMT having a listing of waiver providers from which the consumer chooses for the identified needs. The consumer will sign the plan of care and will receive a copy for his/her files, thus documenting his/her participation in the selection of providers and his/her direct involvement in the plan of care development.

(d)(e) Each individual plan of care shall include at least the following components:

- Diagnosis, symptoms, complaints and complications indicating the need for services;
- A description of the consumer's functional level;
- Specific short-term objectives and long-term goals, including discharge potential or plan;
- Consumer's desired outcome;
- A description of risk factors and special procedures recommended for the health and safety of the consumer;
- Discharge plan;
- Any orders for the following:
  Medication;

Treatments, Including Mental Health Regime;
Restorative and Rehabilitative Services;
Activities;
Therapies;
Social services;
Diet; and
The specific services to be provided, the frequency of services and the types of providers;

- A psychosocial summary describing the consumer's social, emotional, mental and financial situation attached to the initial plan of care;
- A cost sheet which projects the annualized costs of HCBS; and
- Signatures of all individuals who participated in development of the plan of care including the consumer and/or representative and CMT.

(f) All plans of care are subject to review by the Department of Public Health and Human Services (Department). The Department has delegated the review function to the Community Program Officer (CPO). The CPO is responsible for reviewing all portions of the plan utilizing the criteria outlined below. Review of the individual plan of care will be based on the following:

- Completeness of plan which includes all necessary services being listed in terms of amount, frequency and planned provider(s);
- Consistency of the plan with screening information regarding the consumer needs;
- Presence of appropriate signatures; and
- Cost-effectiveness of plan.

The plan of care must provide documentation of the consumer's plan of care costs. It will include all Home and Community Based Services to be provided, the frequency, amount and projected annualized cost of the services. The plan of care will also list the non-waiver services to be utilized by the consumer. The CMT will make all necessary referrals for non-waiver services for the consumer and the consumer has free choice of providers.

The CMT will prepare the plan of care cost sheet after the plan of care has been developed. The cost sheet will be completed to determine initial program eligibility and when amendments are made to the plan of care. A new cost sheet must also be completed at each annual update of the plan of care. The CMT must explain the cost sheet to the consumer and/or representative. CMT will complete final cost plan upon return to office and document mailing of form to the consumer and/or representative. The CMT will review the cost sheet with the consumer during the three-month plan of care review.

(g) Subsequent plans of care must be completed at least annually or when the consumer's condition warrants it. The plan of care is reviewed every three months with the consumer.

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Training and information will be provided to every consumer to prepare them for playing a greater role in the support and service planning and delivery process. The training and information will cover health and safety factors, emergency back up planning, and risk identification, assessment, and management. Consumers will conduct a self-assessment as part of the planning and implementation process. If the consumer's mental condition has decompensated, family members and other supports will be provided the training and information and allowed to participate with the consumer in the self-assessment process.

Emergency back up plans and risk identification and management are included in the consumer's plan of care. Emergency back up plans will be defined and planned for on an individual basis. The emergency back up plan may include an assessment of critical services and a back up strategy for each identified critical service. Back up may include:
1. Consumer backup incorporated into the plan;
2. Informal backup (for example, family, friends, and neighbors);
3. Enrolled Medicaid provider network (for example, personal assistant agencies); and
4. System level (local emergency response). Back up services may be included and paid for by the waiver program.

As part of the quality assurance reviews, the Community Program Officer reviews every service and support plan to assure that it meets health care needs and that there is proper documentation for emergency back up and risk management procedures.

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

During the development of the plan, the consumer will select providers from a list prepared by the Case Management Team (CMT). If the consumer is dissatisfied with the list of available agencies, the CMT will solicit other providers for the service.

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The CMT, as an agent of the Department of Public Health and Human Services, will approve the service plan in conjunction with the consumer. Plans will be reviewed for accuracy by the Community Program Officer (CPO) during the quality assurance process. Plans of care for individuals who exceed the suggested cost limit will be approved by the CPO and by the Addictive and Mental Disorders Division, Department of Public Health and Human Services, staff in the Central Office in Helena, MT.

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. *Specify the minimum schedule for the review and update of the service plan:*

○	Every three months or more frequently when necessary
○	Every six months or more frequently when necessary
✓	Every twelve months or more frequently when necessary
○	Other schedule (*specify*):

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies)*:

○	Medicaid agency
☐	Operating agency
✓	Case manager
☐	Other (*specify):*

Appendix D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The Case Management Team (CMT) will monitor the implementation of the plan of care. The CMT will meet with the consumer at least every three months to ensure that selected services are provided as outlined in the plan of care. These meetings will also address health and welfare of the consumer. The monitoring visits will include a review of the consumer's service utilization history, a review of usage and effectiveness of the emergency back up plan and an evaluation of the quality and effectiveness of services. The CMT will identify any problems that need to be addressed and document the strategy for resolution. Serious Occurrence Reports are mandated for incidents in which the consumer's health and safety are at risk. These reports are sent to the Community Program Officer (CPO) for review. The CPO will become involved in problem solving strategies, as needed, to assist in resolution of issues beyond the scope of the consumer and the case managers.

The service plan is subject to an annual periodic review and update to assess the appropriateness and adequacy of the services for the consumer. This will include a review of consumer access to non-waivers services identified in the plan of care.

The CMT and service providers are mandatory reporters of abuse, neglect, and exploitation. The CMT will complete a Serious Occurrence Report, file a report with the appropriate entity, and send a copy of the report to the CPO for quality assurance monitoring. The CPO provides a quarterly summary to Addictive and Mental Disorders Division, Department of Public Health and Human Services (Central Office) staff. In addition, they will consult with Central Office on any serious occurrences not resolved at the local level, patterns that may be reoccurring or necessary system changes as a result of reports.

b. Monitoring Safeguards. *Select one:*

○	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may not provide* other direct waiver services to the participant.
✓	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:
	Service plans will be reviewed by the Community Program Officer during the quality assurance process to ensure implementation of plan of care and consumer health and welfare. There will be careful review of administrative separateness, if services other than case management were provided by the Case Management Team agency, to ensure the services were medically necessary and the consumer was provided a choice of providers.

Appendix E: Participant Direction of Services

[NOTE: *Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.*]

Applicability *(select one)*:

○	**Yes.** This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
✓	**No.** This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction. Indicate whether Independence Plus designation is requested (select one):

○	**Yes.** The State requests that this waiver be considered for Independence Plus designation.
✓	**No.** Independence Plus designation is not requested.

Appendix E-1: Overview

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

○	**Participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
○	**Participant – Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
○	**Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

☐	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
☐	Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
☐	The participant direction opportunities are available to persons in the following other living arrangements *(specify)*:

d. Election of Participant Direction. Election of participant direction is subject to the following policy (s*elect one):*

○	Waiver is designed to support only individuals who want to direct their services.
○	The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. *Specify the criteria*:

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one)*:

○		The State does not provide for the direction of waiver services by a representative.
○		The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: *(check each that applies)*:
	☐	Waiver services may be directed by a legal representative of the participant.
	☐	Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-3. *(Check the opportunity or opportunities available for each service)*:

Participant-Directed Waiver Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

○	**Yes**. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i)*. Specify whether governmental and/or private entities furnish these services. *Check each that applies:*
	☐ Governmental entities
	☐ Private entities
○	**No**. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i.*

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. S*elect one*:

○	FMS are covered as the waiver service entitled	
	as specified in Appendix C-3.	
○	FMS are provided as an administrative activity. *Provide the following information:*	
	i.	**Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:
	ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:
	iii.	**Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*
		Supports furnished when the participant is the employer of direct support workers:
		☐ Assist participant in verifying support worker citizenship status
		☐ Collect and process timesheets of support workers
		☐ Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
		☐ Other *(specify):*

		Supports furnished when the participant exercises budget authority:
	☐	Maintain a separate account for each participant's participant-directed budget
	☐	Track and report participant funds, disbursements and the balance of participant funds
	☐	Process and pay invoices for goods and services approved in the service plan
	☐	Provide participant with periodic reports of expenditures and the status of the participant-directed budget
	☐	Other services and supports *(specify)*:
		Additional functions/activities:
	☐	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
	☐	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
	☐	Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
	☐	Other *(specify):*
iv.		**Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐	**Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*
☐	**Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled:

☐	**Administrative Activity**. Information and assistance in support of participant direction are furnished as an administrative activity. *Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

k. Independent Advocacy *(select one)*.

○	**Yes.** Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy*:
○	**No.** Arrangements have not been made for independent advocacy.

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	**Budget Authority Only or Budget Authority in Combination with Employer Authority**
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

Appendix E-2: Opportunities for Participant-Direction

a. Participant – Employer Authority *(Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b)*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Check each that applies:*

☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. *Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff:*
☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Check the decision making authorities that participants exercise*:

☐	Recruit staff
☐	Refer staff to agency for hiring (co-employer)
☐	Select staff from worker registry
☐	Hire staff (common law employer)
☐	Verify staff qualifications
☐	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
☐	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
☐	Determine staff duties consistent with the service specifications in Appendix C-3.
☐	Determine staff wages and benefits subject to applicable State limits
☐	Schedule staff
☐	Orient and instruct-staff in duties
☐	Supervise staff
☐	Evaluate staff performance
☐	Verify time worked by staff and approve time sheets
☐	Discharge staff (common law employer)
☐	Discharge staff from providing services (co-employer)
☐	Other *(specify)*:

b. Participant – Budget Authority *(Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b)*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Check all that apply***:**

☐	Reallocate funds among services included in the budget
☐	Determine the amount paid for services within the State's established limits
☐	Substitute service providers
☐	Schedule the provision of services
☐	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3
☐	Specify how services are provided, consistent with the service specifications contained in Appendix C-3
☐	Identify service providers and refer for provider enrollment
☐	Authorize payment for waiver goods and services
☐	Review and approve provider invoices for services rendered
☐	Other *(specify):*

ii. Participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

iv. Participant Exercise of Budget Flexibility. *Select one:*

○	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
○	Modifications to the participant-directed budget must be preceded by a change in the service plan.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Consumers will be notified of the fair hearing process by eligibility staff when they complete the Medicaid application process. Consumers will also be notified of the fair hearing process by the Mountain Pacific Quality Health Foundation when they receive the choice of waiver or institutional services during level of care assessment process. Consumers will be notified of the fair hearing process by Case Management Teams (CMTs) when information is provided on choice of providers of service or when there is an adverse action such as a denial, reduction, suspension or termination of services. CMTs will also specify to the consumers that they will continue to receive waiver services during the period while the appeal is under consideration. CMTs will provide information regarding the fair hearing process on an on-going basis through their routine involvement with the consumers.

Resources for waiver consumers in the fair hearing process include the Mental Health Ombudsman, Montana Advocacy Program and personal attorneys of the consumers and/or families. All documentation that consumers were provided notification of the fair hearing process will be kept in the respective agency files.

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one*:

○	**Yes**. The State operates an additional dispute resolution process *(complete Item b)*
✓	**No**. This Appendix does not apply (*do not complete Item b)*

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

○	**Yes.** The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver *(complete the remaining items)*.
✓	**No.** This Appendix does not apply (*do not complete the remaining items*)

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents, and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All persons employed by an agency participating in the waiver program are mandatory reporters of suspected abuse, neglect or exploitation of children, elderly, or consumers with disabilities. They are also required to complete a Serious Occurrence Report (SOR), DPHHS-MA-129, when warranted. At this time, the SOR is not electronically submitted. The SOR must be completed anytime an individual's life, health, or safety has been put at risk. This includes all reports for suspected abuse, neglect or exploitation submitted to Adult Protective Services (APS) or Child Protective Services (CPS). In addition, circumstances warranting a SOR include:

- Suspected or known physical or verbal abuse
- Neglect of the consumer, self-neglect or neglect by responsible caregivers
- Sexual harassment by an agency employee or consumer
- Injuries requiring medical intervention to an agency employee or consumer
- An unsafe working environment which puts the worker at risk

All Case Management Teams (CMTs) and service providers are mandated to immediately refer all suspected abuse, neglect or exploitation to APS or CPS. CMTs and service providers must also complete the SOR and notify the Community Program Officer (CPO) within ten working days of their referral to APS or CPS. The provider agency must document cause and effect of the incident and the action plan to correct or prevent incidents from occurring in the future. The CPO is responsible for ensuring an appropriate response by the provider agency. The designated state agency (e.g. APS or CPS) will monitor the provider agency to ensure the corrective action plan was activated and identified issues resolved. The CPO will obtain copies of documentation to ensure compliance has occurred.

b. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Information on identifying, addressing, and protecting someone from abuse, neglect and exploitation and how to notify the appropriate authorities will be provided to consumers during the development of the plan of care. The Case Management Teams will continue to provide this information upon the annual renewal of the plan of care. Consumers can also access information on the Department of Public Health and Human Services (Department) website. Information on incident management, abuse, neglect and exploitation and consumer protection will be covered as special training topics by the Mental Health Services Bureau in the Central Office for the Community Program Officers (CPOs). Training and education for the CPOs will occur on an

annual basis or as changes in policies are made.

c. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Investigations involving Abuse, Neglect and Exploitation and/or criminal activity:

Reports of abuse, neglect and exploitation are made to Adult Protective Services (APS) or Child Protective Services (CPS) for evaluation, reporting, and investigation. Adult and Child Protective Services are emergency intervention activities which may include: investigating complaints, coordinating family and community support resources, strengthening current living situations, developing and protecting personal financial resources and facilitating legal intervention. All reports come through a centralized intake hotline where trained staff assess the situation and send a report to field staff. Local APS or CPS social workers evaluate, assess, prioritize and follow-up on all cases within their jurisdiction.

Child Protective Services are provided to children under the age of 18 in the state of Montana. The response timeline for CPS reports depends on the incident. Any report that is assessed at the level of imminent danger is responded to within 24 hours. For all other reports, response time varies depending on the nature of the report, location, and whether local law enforcement is involved. Before a case is closed a safety assessment is conducted to assess whether appropriate action was taken.

Adult Protective Services are provided to persons over the age of 60, physically or mentally disabled adults (as defined by the Department through SSI or vocational rehabilitation) and adults with developmental disabilities who are at risk of physical or mental injury, neglect, sexual abuse or exploitation. APS provides voluntary protective services to any individual in their jurisdiction. However, APS is unable to provide involuntary protective services to physically or mentally disabled adults under the age of 60. All APS reports are assessed by regional supervisors for imminent risk and capacity of the individual. Cases are triaged using social work methodology and serious cases are responded to first. A computer data system has a built in alert system to track cases and open investigations. Any report that is referred for investigation has 90 days to be closed.

APS, CPS, Medicaid providers and Community Program Officers (CPOs) make referrals, when necessary, to local law enforcement or other entities. Referrals to local law enforcement include illegal activities, theft, embezzlement and incidents involving significant abuse.

Investigations outside the scope of APS, CPS and local law enforcement:

Incidents and events outside the scope of APS, CPS or local law enforcement authority are reported to the pertinent provider agency. The agency investigates the incident and provides follow-up, when needed. The provider agency documents the scope of the incident, the incident's cause and effect, and work with the consumer to develop an action plan to correct or prevent the incident from reoccurring in the future. This information is captured on a Serious Occurrence Report (SOR). A copy of the SOR must be provided to the CPO within 10 days. The CPO will follow up on the SOR to ensure that the incidents are being addressed and resolved as they occur and during the quality assurance reviews. The CPO is responsible for insuring an appropriate and timely response is provided by the provider agency. On the SOR form there is a section where the CPO may comment on the incident and mark any follow-up action taken, including providing training,

case conference, and/or sanctions.

d. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Department of Public Health and Human Services, Addictive and Mental Disorders Division (AMDD), Mental Health Services Bureau (MHSB) in the Central Office is responsible for overseeing the operation of the serious occurrence incident management system. All critical events or incidents involving a waiver consumer warrant a Serious Occurrence Report (SOR) that is sent to the local CPO who oversees the incident management process and ensures that appropriate reporting and follow-up occurs at the local level.

Consumers, providers, and regional staff (CPOs) will have the opportunity to review public reports and provide input on developing effective and strategic prevention strategies.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

This Appendix must be completed when the use of restraints and/or restrictive interventions is permitted during the course of the provision of waiver services regardless of setting. When a state prohibits the use of restraints and/or restrictive interventions during the provision of waiver services, this Appendix does not need to be completed except for Item G-2-c-ii.

a. Applicability. *Select one:*

✓	This Appendix is not applicable. The State does not permit or prohibits the use of restraints or restrictive interventions *(complete only Item G-2-c-ii)*	
○	This Appendix applies. Check each that applies:	
	☐	The use of personal restraints, drugs used as restraints, mechanical restraints and/or seclusion is permitted subject to State safeguards concerning their use. *Complete item G-2-b.*
	☐	Services furnished to waiver participants may include the use of restrictive interventions subject to State safeguards concerning their use. *Complete item G-2-c.*

b. Safeguards Concerning Use of Restraints or Seclusion

i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

c. Safeguards Concerning the Use of Restrictive Interventions

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G-3: Medication Management and Administration

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

✓	**Yes**. This Appendix applies *(complete the remaining items)*.
○	**No**. This Appendix is not applicable *(do not complete the remaining items)*.

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Staff in licensed assisted living facilities and licensed group homes provides medication management for self-administered medication. They are responsible for keeping track of medication and ensuring the consumers take their medications as prescribed. Medication is kept in a lock box thus restricting access by other residents. Assisted living facilities utilize a bubble pack filled by a pharmacy whenever possible. Group homes always utilize a bubble pack system. In addition, group home staff is required to take a test and be certified to manage and assist with self-administered medication. Staff in licensed assisted living facilities and licensed group homes will refer all medication errors to their respective management and complete the Serious Occurrence Report. Management will work with the Case Management Teams where waiver consumers are involved.

The Quality Assurance Division, Licensing Bureau, is responsible for the issuance of licenses to assisted living facilities and group homes. Annual reviews are completed to ensure compliance in the area of medication regimens. Reviews may occur more frequently if warranted.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Department of Public Health and Human Services, Quality Assurance Division, Licensing Bureau, ensures the appropriate management of medication during quality assurance reviews. The point-of-sale system used by pharmacy providers has a set of built-in edits to inform the pharmacist of potential contraindicated effects such as drug-to-drug interaction and therapeutic duplications. There is also a prior authorization process based on clinical criteria established the Drug Utilization Review Board for the Department. Through periodic reviews, Case Management Teams (CMTs) will monitor that consumers on the waiver receive their medication as prescribed and will report any mismanagement, harmful practices or crimes to the appropriate authorities. CMTs will be required to complete necessary documentation to report any serious occurrences. Oversight and follow-up are the responsibility of the Quality Assurance Division, Licensing Bureau.

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one*:

✓	Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*
○	Not applicable (*do not complete the remaining items*)

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Licensed practical nurses and registered nurses administer medication as outlined in the Nurse Practice Act of Montana.

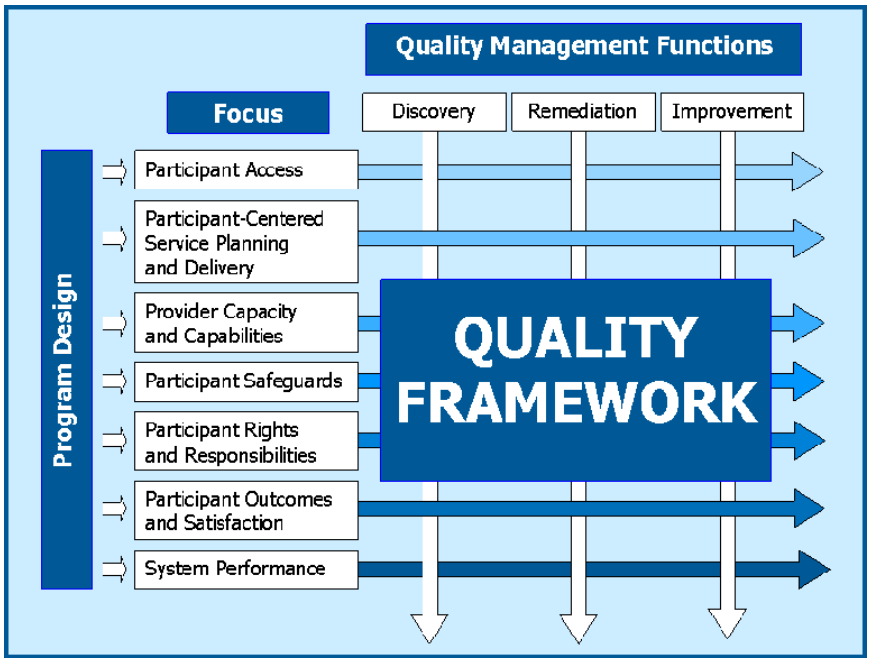
iii. Medication Error Reporting. *Select one of the following:*

○	Providers that are responsible for medication administration are required to *both* record and report medication errors to a State agency (or agencies). *Complete the following three items:*
	(a) Specify State agency (or agencies) to which errors are reported:
	(b) Specify the types of medication errors that providers are required to *record:*
	(c) Specify the types of medication errors that providers must *report* to the State:
✓	Providers responsible for medication administration are required to *record* medication errors but make information about medication errors available only when requested by the State. Specify the types of medication errors that providers are required to record:
	Providers must record medication doses missed or refused by resident and why, and unexpected effects of medication or medication error.

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The State Medicaid Agency is responsible for monitoring the performance of waiver providers in the self-administration of medications to consumers on the waiver. Licensed facilities are monitored by the Department of Public Health and Human Services Licensing Bureau. CMTs, during their review processes or as necessary, evaluate the self-administration of medication by waiver providers.

Appendix H: Quality Management Strategy



Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

Quality Management is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement. A Quality Management Strategy is explicitly describes the processs of discovery, remediation and improvement; the frequency of those processes; the source and types of information gathered, analyzed and utilized to measure performance; and key roles and responsibilities for managing quality.

CMS recognizes that a state's waiver Quality Management Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Management Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy will be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

1. **The Quality Management Strategy must describe how the state will determine that each waiver assurance and requirement is met.** The applicable assurances and requirements are: (a) level of care determination; (b) service plan; (c) qualified providers; (d) health and welfare; (e) administrative authority; and, (f) financial accountability. For each waiver assurance, this description must include:
   - Activities or processes related to discovery, i.e. monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery are provided in the application in Appendices A, B, C, D, G, and I. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance. The description of the Quality Management Strategy should not repeat the descriptions that are addressed in other parts of the waiver application;
   - The entities or individuals responsible for conducting the discovery/monitoring processes;
   - The types of information used to measure performance; and,
   - The frequency with which performance is measured.
2. **The Quality Management Strategy must describe roles and responsibilities of the parties involved in measuring performance and making improvements. Such parties include (but are not limited to) the waiver administrative entities identified in Appendix A, waiver participants, advocates, and service providers.**

   Roles and responsibilities may be described comprehensively; it is not necessary to describe roles and responsibilities assurance by assurance. This description of roles and responsibilities may be combined with the description of the processes employed to review findings, establish priorities and develop strategies for remediation and improvement as specified in #3 below.
3. **Quality Management Strategy must describe the processes employed to review findings from its discovery activities, to establish priorities and to develop strategies for remediation and improvement.** *The description of these process(es) employed to review findings, establish priorities and develop strategies for remediation and improvement may be combined with the description of roles and responsibilities as specified in # 2 above.*
4. **The Quality Management Strategy must describe how the State compiles quality management information and the frequency with which the State communicates this information (in report or other forms) to waiver participants, families, waiver service providers, other interested parties, and the public.** *Quality management reports may be designed to focus on specific areas of concern; may be related to a specific location, type of service or subgroup of participants; may be designed as administrative management reports; and/or may be developed to inform stakeholders and the public.*
5. **The Quality Management Strategy must include periodic evaluation of and revision to the Quality Management Strategy. Include a description of the process and frequency for evaluating and updating the Quality Management Strategy**.

If the State's Quality Management Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Management Strategy, including the specific tasks that the State plans to undertake during the period that the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Management Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

Attachment #1 to Appendix H

The Quality Management Strategy for the SDMI waiver is:The Addictive and Mental Disorders Division (AMDD or Division) of the Department of Public Health and Human Services (Department) will conduct comprehensive evaluations of services to Home and Community Based Services (HCBS) consumers to meet the Division's quality assurance requirements. AMDD staff will perform announced quality assurance reviews. The purpose of the review is to ensure that optimal services are being provided to consumers and that program rules and policies are being followed. Quality assurance results will be utilized to improve the programs and services.

In General

The Quality Management (QM) process will involve a strategy to ensure that individual consumers have access to and are receiving the appropriate services to meet their needs. This will require ongoing development and utilization of individual quality standards, and working with case management teams to evaluate individualized personal outcomes and goals.

The QM process will also involve a strategy designed to collect and review data gathered from providers and individual consumers on quality assurance measures. Provider standards and quality indicators are used to ensure that quality assurances are met. At the Division level in the Helena office, the Quality Management Committee will identify trends and systemic issues and provide remediation, as necessary. Each of the Waiver assurances and other federal requirements will be addressed below at varying levels of responsibility, beginning with the field agents (Community Program Officers; CPOs). Their responsibilities will be the utilization of discovery and monitoring methods, through reviews of consumer clinical records, specifically to include service plans, comparison with up-to-date documentation of service claims paid, and interviews with staff and consumers to evaluate areas of strength and weakness in the overall program. A Quality Management Committee will be assembled to serve as an intermediate quality improvement entity. Their role will be to monitor the discovery activities of the CPOs; to evaluate their submitted information; and to participate in policy decisions that address provider or system deficiencies. They, in turn, will report to Division Management staff through formal reports and meetings, and will keep the Division informed regarding the effectiveness with which qualifying providers support Waiver consumers. Recovery markers have been established as performance/outcome indicators. These include the domains of *Employment; Level of Symptom Interference; Housing; Substance Abuse (stages of change and level of use).* Each domain contains items that will be scored and submitted quarterly through a secure web based application by case managers to the State Mental Health Authority for analysis, review, and distribution to the Quality Management Committee and other invested stakeholders. All reports will contain only summarized data to ensure consumer confidentiality. The State Mental Health Authority currently administers an annual nationally standardized Consumer Satisfaction Survey that measures *Access* to services; *Quality and Appropriateness* of services; *Consumer Satisfaction* with services; consumer perspective on *Outcomes*; and consumer *Participation in Treatment Planning*. This survey will be modified where appropriate to obtain optimal feedback from consumers regarding the Waiver service program.

CPO QA Roles and Responsibilities

Community Program Officers (CPOs) will be charged with the role of regular review and monitoring of planning, documentation, quality, and delivery of services to HCBS Waiver service consumers. The CPO will approve the initial plans of care for consumers enrolling into the SDMI Waiver. The CPO will interview HCBS Waiver consumers to ensure the consumers are in charge of their plans of care development; they agreed to all of the services outlined in their plans of care; they had freedom of choice of service providers; and they signed their plans of care and retained copies for their files.

1. Level of Care (LOC) determinations will be the function of the Mountain Pacific Quality Health Foundation (MPQHF). In a situation where the consumer may not appear to meet nursing facility level of care criteria as

determined by MPQHF, the CPO will conduct an on-site review of the consumer's needs, situation and status. If there is additional information to warrant a change in the MPQHF's initial determination, the CPO will consult with MPQHF and a nursing facility LOC decision will be made.

Chart reviews will include an evaluation of the need for and inclusion of a written evaluation for LOC for all applicants for whom there is reasonable indication that services may be needed in the future. Also included in charts will be annual reevaluations of LOC. The Case Management Teams (CMTs) will keep a tickler filing system as an alert when a waiver consumer is nearing his/her annual LOC review. The CMT will contact the MPQHF in a timely manner and request a reevaluation of the consumer's LOC.

2. Consumer Service Plan reviews will ensure that care plans address all of the consumers' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other formal and informal means. Service plans will be reviewed with the consumer at least every 90 days or when warranted by changes in the waiver participant's needs. CPOs will verify the documentation of selection of waiver services or institutional care by consumers; and selection of waiver services and providers, as indicated by the consumer's signature. A new plan will be written annually.

Quality Management Committee Roles and Responsibilities

The Quality Management Committee (QMC; currently under development) will include consumers, providers, Division officials, and members of the Mental Health Oversight and Advisory Council. It is expected that the QMC will meet at least quarterly, and presumably more frequently during the strategic planning and mission development phase. The Mental Health Quality Assurance Manager will facilitate the Committee meetings. The Quality Assurance Manager holds a doctorate in psychology program evaluation with an emphasis on public policy. Roles and responsibilities of this committee will include, but will not be limited to:

a) Work with the Division Management team to establish and monitor performance standards;
b) Serve as a liaison between the CPOs and the Division's Management staff;
c) Review information from the discovery methods utilized and documented by CPOs on an ongoing basis, and based upon Departmental policy, issue a corrective action that identifies deficiencies. The Committee will provide remediation where appropriate, monitoring and follow-up of remediation activity; document the final outcome, and issue a report to the provider and the Division's Management staff;
d) Review the information submitted by the CPOs and note any trends, patterns, systemic issues of concern, as well as positive changes and improvements that support the goals and objectives of the Waiver;
e) Evaluate the CPOs' QA review activities to ensure consistency, comprehensiveness, and quality of the review process. Consumer chart reviews will be conducted on a rotating basis among HCBS waiver case managers; to include all case managers at least annually. In cases of discrepancies between a CPO and case management team review determination the Committee will provide mediation, training, and discussion until resolution is achieved;
f) Track performance indicators on at least a quarterly basis;
g) Respond to issues that arise from the QM database and CPO reports;
h) Review and revise the QM strategy as the program evolves; and
i) Generate performance reports to Division Management staff, Waiver case management teams, Advisory Council, and other invested stakeholders.

State Roles and Responsibilities

1. Level of Care (LOC) decision monitoring:
The state will monitor LOC decisions and take action to address inappropriate LOC determinations. This function will be the responsibility of the Mental Health Bureau's Clinical Manager, a Clinical Ph.D. psychologist. Mountain Pacific Quality Health Foundation is contracted to perform initial level of care evaluations and annual level of care reevaluations. If a Case Management Team (CMT) has a concern that a waiver consumer may no longer meet nursing facility level of care criteria, the CMT may contact the MPQHF and request a level of care reevaluation. Annually, the CMT will contact MPQHF for a LOC reevaluation of the waiver consumer. The same screening determination tool is used for the initial level of care determination and subsequent level of care

determinations.

2. Service Plan:
a) Services will be delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan. This task will be monitored by State Mental Health Bureau Staff through a database that matches services reimbursed by Medicaid for Waiver consumers with service plan goals. CPOs will be provided records of services by consumer to compare with service plans. Discrepancies will be referred to the QM Committee for further review.
b) The CPO will authorize the initial plans of care for consumers enrolling into the waiver. This initial exposure to the plans of care will familiarize the CPOs with the consumers and their needs and provide an opportunity to work directly with the CMTs. CPOs will be available to problem-solve difficult situations as requested by the CMTs.
c) Through annual reviews of the CMTs records, CPOs will determine that plans of care for waiver consumers were updated annually or more frequently as needed.
d) The annual reviews will provide documentation the consumer was afforded the choice between waiver services and institutional care; offered free choice of waiver providers; and was directly involved in the development of the plan of care.
e) Discrepancies will be reported to the Quality Management Committee.

3. Qualified Providers:
a) The Department will verify that providers meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.
b) The Department will verify on a periodic basis that providers continue to meet required licensure and/or certification standards and/or adhere to other state standards.
c) All HCBS Waiver service providers must be licensed in their field of expertise. ACS, the Department's fiscal agent, will verify licenses of service providers on a regular basis. If a provider does not have an active license, ACS will inactivate the provider number and notify the provider and the Department.
d) The Department will identify and remediate situations where providers do not meet requirements.
e) The Department will implement policies and procedures for verifying that provider training has been conducted in accordance with state requirements and the approved waiver.

4. Health and Welfare:
a) There will be continuous monitoring of the health and welfare of waiver participants and remediation actions will be initiated when appropriate.
b) The Department, on an on-going basis, will identify, address and seek to prevent the occurrence of abuse, neglect and exploitation.
c) All suspected occurrences of abuse, neglect and exploitation will be reported to the appropriate agency.
d) Any corrective action plans identified to remedy a situation will be documented and results provided to the appropriate State agency. CMTs and waiver providers will cooperate to prevent any further occurrences of abuse, neglect, or exploitation.
e) The Mental Health Services Bureau will ensure ongoing training of CPOs and CMTs in the areas of health and welfare of waiver consumers will occur annually.

5. Administrative Authority:
a) The Montana Department of Public Health and Human Services, Addictive and Mental Disorders Division will retain ultimate authority and responsibility for the operation of the waiver by exercising oversight over the performance of waiver functions of contracted entities.
b) The CPOs will conduct annual reviews of the CMTs records to ensure services were provided to waiver consumers in accordance with their identified needs. These annual reviews will encompass interviews with CMT staff; other waiver providers and the consumers of the waiver.
c) The Division may request an audit from the Audit and Compliance Bureau if determined necessary by the Mental Health Services Bureau through activities completed by the CPOs.

6. Financial Accountability:

a) Claims for federal financial participation in the costs of waiver services are based on state payments for waiver services that have been rendered to waiver consumers, authorized in the service plan and properly billed by qualified waiver providers in accordance with the approved waiver.

b) The CPOs will complete a comparison of up-to-date documentation of paid claims data with the consumers' plan of care to ensure accurate billing of services occurred in accordance with those services outlined in the plans of care. The Division will have a data base that compiles the paid claims history from ACS (fiscal agent) for the waiver consumer and allows the CPO to match the information with the plan of care. This review process will occur annually for each waiver consumer.

c) The Division will provide ongoing training to each CMT to ensure accuracy of coding and payments. The Mental Health Services Bureau staff, including CPOs, will meet annually with CMTs. If there is a CMT experiencing issues with billing deficiencies, meetings will occur more frequently.

d) The QM process will also involve a strategy designed to collect and review data gathered from providers and individual consumers on quality assurance measures. Provider standards and quality indicators are used to ensure that quality assurances are met (see Appendix H:4 for details).

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department of Public Health and Human Services (Department) provides financial oversight to assure that claim coding and payment are in line with the waiver reimbursement methodology. Paid claims reports will be run by the Mental Health Services Bureau of the Department on at least a monthly basis (or as needed). These reports will depict the services utilized, the number of consumers using each service, the number of units utilized, and the total dollar amount paid for each service. As a part of the quality assurance reviews, financial accountability will be assessed. Charts will be reviewed by MHSB staff to ensure that no payments were made for waiver services when a consumer was permanently or temporarily discharged from waiver services. The Audit and Compliance Bureau of the Department will conduct financial audits upon request of the Addictive and Mental Disorders Division, Mental Health Services Bureau. The Audit and Compliance Bureau is further mandated to perform reviews for any and all areas of suspected overpayments and as such, may be completing financial audits relative to the SDMI waiver providers without being directly referred by the Mental Health Services Bureau. Audits will be conducted in compliance with the single state audit act.

APPENDIX I-2: Rates, Billing and Claims

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Payments for waiver services will be consistent with efficiency, economy and quality of care and will be sufficient to enlist enough providers. Services will be reimbursed via fee for service; there will be no interim rates, no prospective payments, and no cost settlements. The Department of Public Health and Human Services (Department) will take into consideration the difficulty of care factors for some of the waiver services.

The Department's Senior and Long Term Care (SLTC) Division has operated a home and community based waiver program for elderly and physically disabled consumers since the early 1980's. SDMI HCBS waiver service descriptions that are the same or similar as the SLTC HCBS waiver, will use the established fee schedule. The Department envisions many of the same service providers will provide waiver services to both waivers' participants and having the same fee schedule will ensure uniformity of rates. In addition, the rate setting methodology will be defined in the Administrative Rules of Montana for the HCBS Waiver for Adults with Severe Disabling Mental Illness. The rule process solicits written and oral comments from the public through a formal hearing.

The Department has a Rates Commission to review how rates are established for new programs or services. The 2005 Legislature created this commission to advise the Montana Department of Public Health and Human Services (DPHHS) concerning provider services, costs, and reimbursement rates. The commission is to assist the department in providing a regular, predictable, and equitable mechanism under which rates can be established for contracted services, provided in a community setting, for people who are developmentally disabled, mentally ill, very elderly, or very young. (MCA 53-10-201). The commission is made up of providers, consumers or their family members, legislators, and legislative and executive budget and program staff. Members are appointed by the department director for two-year terms, with the first term being staggered between two- and four-year terms.

Reimbursement for waiver services is established pursuant to ARM PROPOSED RULE V.

ARM PROPOSED RULE V. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: REIMBURSEMENT

(1) Services available through the program are reimbursed as specified in this rule.
(2) The following services are reimbursed as provided in (3):
- (a) Homemaking;
- (b) Adult day health;
- (c) Habilitation;
- (d) Personal emergency response systems;
- (e) Nutrition;
- (f) Psycho-social consultation;
- (g) Nursing;

(h) Dietetic services;
(i) Specially trained attendant care;
(j) Chemical dependency counseling;
(k) Supported living;
(l) Specialized medical equipment and supplies;
(m) Adult residential care;
(n) Respite care not provided by a nursing facility;
(o) Non-medical transportation;
(p) Illness Management and Recovery; and
(q) Wellness Recovery Action Plan.

(3) The services specified in (2) are, except as otherwise provided in (4), reimbursed at the lower of the following:
(a) The provider's usual and customary charge for the service; or
(b) The rate negotiated with the provider by the case management team up to the department's maximum allowable fee.

(4) The services specified in (2) are reimbursed as provided in (3) except that reimbursement for components of those services that are incorporated by specific cross-reference from the general Medicaid program may only be reimbursed in accordance with the reimbursement methodology applicable to the component service as a service of the general Medicaid program.

(5) The following services are reimbursed in accordance with the referenced provisions governing reimbursement of those services through the general Medicaid program:

(a) Personal Assistance as provided at ARM 37.40.1105; and

(b) Outpatient occupational therapy as provided at ARM 37.86.610;

(6) Case management services are reimbursed, as established by contractual terms, on either a per diem or hourly rate.

(7) Respite care services provided by a nursing facility are reimbursed at the rate established for the facility in accordance with ARM Title 37, chapter 40, subchapter 3.

(8) Reimbursement is not paid for a service that is otherwise available from another source.

(9) No co-payment is imposed on services provided through the program but recipients are responsible for co-payment on other services reimbursed with Medicaid monies.

(10) Reimbursement is not available for the provision of services to other members of a recipient's household or family unless specifically provided for in these rules. (ARM PROPOSED RULE III. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: PROVIDER REQUIREMENTS (3) A provider may also provide support to other family members in the recipient's household during hours of program reimbursed service if approved by the case management team)

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Waiver service providers bill Montana Medicaid through the MMIS. Payments are issued directly

to the providers; no funds are retained by the Department or by the State.

c. Certifying Public Expenditures *(select one)*:

○	**Yes**. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid (*check each that applies*):
☐	**Certified Public Expenditures (CPE) of State Public Agencies**. Specify: (a) the public agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)
☐	**Certified Public Expenditures (CPE) of Non-State Public Agencies**. Specify: (a) the non-State public agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)
✓	**No**. Public agencies do not certify expenditures for waiver services.

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The state's MMIS has a recipient eligibility system that verifies eligibility for Medicaid and the waiver. Case managers will prior authorize all waiver services in the consumer's plan of care. These prior authorizations will be submitted to the state's fiscal intermediary, ACS. The quality assurance plan includes a process to verify that payments for services were made in accordance with the plan of care and no waiver services were paid for a consumer who was discharged from the waiver.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §74.53.

APPENDIX I-3: Payment

a. Method of payments — MMIS *(select one)*:

✓	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
○	Payments for some, but not all, waiver services are made through an approved MMIS. Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
○	Payments for waiver services are not made through an approved MMIS. Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
○	Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities:

b. Direct payment. Payments for waiver services are made utilizing one or more of the following arrangements (*check each that applies*):

☐	The Medicaid agency makes payments directly to providers of waiver services.
✓	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
☐	The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent. Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:
☐	Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity. Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

✓	**No**. The State does not make supplemental or enhanced payments for waiver services.
○	**Yes**. The State makes supplemental or enhanced payments for waiver services. Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

d. Payments to Public Providers. *Specify whether public providers receive payment for the provision of waiver services.*

✓	**Yes.** Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. *Complete item I-3-e.*
	Nursing facilities that receive county tax dollars may provide respite services to consumers who are on the SDMI waiver. Local city-county health departments that receive city or county tax dollars may provide case management services or direct nursing services to consumers who are on the SDMI waiver. Community mental health centers that receive county tax dollars may provide professional mental health services and case management services (as defined in Appendix C, Case Management Team) to consumers who are on the SDMI waiver.
○	**No**. Public providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

e. **Amount of Payment to Public Providers**. Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one*:

✓	The amount paid to public providers is the same as the amount paid to private providers of the same service.
○	The amount paid to public providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
○	The amount paid to public providers differs from the amount paid to private providers of the same service. When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

✓	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
○	Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):
○	Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment. Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

○	**Yes**. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e). Specify the governmental agency (or agencies) to which reassignment may be made.
✓	**No**. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

ii. Organized Health Care Delivery System. *Select one:*

○	**Yes**. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10. Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:
✓	**No**. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

○	The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.
○	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain *waiver* and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
✓	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

APPENDIX I-4: Non-Federal Matching Funds

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Check each that applies:*

✓	**Appropriation of State Tax Revenues to the State Medicaid agency**
☐	**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:
☐	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by public agencies as CPEs, as indicated in Item I-2- c:

b. Local or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Check each that applies:*

☐	**Appropriation of Local Revenues.** Specify: (a) the local entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
☐	**Other non-State Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
✓	**Not Applicable**. There are no non-State level sources of funds for the non-federal share.

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources. *Check each that applies.*

☐	Provider taxes or fees
☐	Provider donations
☐	Federal funds (other than FFP)
	For each source of funds indicated above, describe the source of the funds in detail:
✓	None of the foregoing sources of funds contribute to the non-federal share of computable waiver costs.

APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○	No services under this waiver are furnished in residential settings other than the private residence of the individual. (*Do not complete Item I-5-b*).
✓	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. (*Complete Item I-5-b*)

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The Department sets reimbursement for room and board in residential settings. Upon admission, providers are notified that the waiver will not cover the cost of room and board for the recipient. The cost calculation sheet utilized by the case managers to determine reimbursement for services has a line item for room and board, which is identified as the responsibility of the consumer.

Room and Board: Enter the correct amount the consumer pays to the facility. This will always equal the current Medically Need Income level ($545) minus $100.

The following outlines the responsibility of payment to the facility:

Daily Rate Computation

(A1) Room and Board _____

(A2) SSI used for AR services _____

(A3) Other _____

Subtotal of consumer responsibilities: (A1 + A2 + A3)_____

APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.
Select one:

○	**Yes**. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services. *The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:*
✓	**No.** The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services as provided in 42 CFR §447.50. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

✓	**No**. The State does not impose a co-payment or similar charge upon participants for waiver services. (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes**. The State imposes a co-payment or similar charge upon participants for one or more waiver services. (*Complete the remaining items*)

i. Co-Pay Arrangement Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies)*:

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*	
☐	Nominal deductible
☐	Coinsurance
☐	Co-Payment
☐	Other charge *(specify)*:

ii Participants Subject to Co-pay Charges for Waiver Services. Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded. The groups of participants who are excluded must comply with 42 CFR §447.53.

iii. Amount of Co-Pay Charges for Waiver Services. In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge. The amount of the charge must comply with the maximum amounts set forth in 42 CFR §447.54.

Waiver Service	Amount of Charge	Basis of the Charge

iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

○	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
○	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

v. Assurance. In accordance with 42 CFR §447.53(e), the State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one:*

✓	**No**. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
☐	**Yes**. The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income as set forth in 42 CFR §447.52; (c) the groups of participants subject to cost-sharing and the groups who are excluded (groups of participants who are excluded must comply with 42 CFR §447.53); and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Level(s) of Care *(specify)*:			Nursing Facility				
Col. 1	**Col. 2**	**Col. 3**	**Col. 4**	**Col. 5**	**Col. 6**	**Col. 7**	**Col. 8**
Year	**Factor D**	**Factor D′**	**Total: D+D′**	**Factor G**	**Factor G′**	**Total: G+G′**	**Difference (Column 7 less Column 4)**
1	17,770	12,000	29,770	51,465	2,175	53,640	23,870
2	15,657	13,000	28,657	54,020	2,284	56,304	27,647
3	15,783	14,000	29,783	56,575	2,389	58,964	29,181
4							
5							

Appendix J-2 - Derivation of Estimates

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
Year 1	105	Nursing Facility	
Year 2	125	Nursing Facility	
Year 3	125	Nursing Facility	
Year 4 (renewal only)			
Year 5 (renewal only)			

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-d.

The average length of stay for the first year of the waiver was computed using the total number of available waiver days (which is approximately 210 days less due to phase-in) divided by the potential number of unduplicated enrollees. The total number of available waiver days computed for Waiver Years Two and Three represents 365 days of available waiver days divided by the potential number of unduplicated enrollees. As this is a new waiver, figures may change based on a number of factors. The 372 report for the first year of the waiver will provide more accurate data and if significant differences are reflected, an amendment will be requested from the Centers for Medicare and Medicaid Services.

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The Senior and Long Term Care Division recently received approval for the renewal of their Home and Community Based Services Waiver for Elderly and Physically Disabled individuals. This data provided the basis for the calculations used in Factor D of the SDMI Waiver. Their data for the number of users reflected in Column 2 was calculated into a percentage of the total number of participants and that percentage was applied to the potential number of participants to be served in the SDMI Waiver. The services identified specifically for mental illness were assigned a higher number of users as this waiver represents a rehabilitation and recovery model. Waiver Year One may reflect a slightly higher number of average units per user as the first year of the waiver will be phased in.

The fee schedule utilized by Senior and Long Term Care's Elderly and Physically Disabled

Waiver will, for the most part, be the same fee schedule for the SDMI waiver. Those specific mental health services have an established fee schedule for the service to be provided.

The 372 report for the first year of the waiver will provide more accurate data and if significant differences are reflected, an amendment will be requested from the Centers for Medicare and Medicaid Services.

ii. Factor D′ Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates of Factor D' for each waiver year are from the Senior and Long Term Care's Elderly and Physically Disabled Waiver for nursing facility level of care (recently approved in their waiver renewal).

The 372 report for the first year of the waiver will provide more accurate data and if significant differences are reflected, an amendment will be requested from the Centers for Medicare and Medicaid Services.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates of Factor G for each waiver year are from the Senior and Long Term Care's Elderly and Physically Disabled Waiver for nursing facility level of care (recently approved in their waiver renewal).

The 372 report for the first year of the waiver will provide more accurate data and if significant differences are reflected, an amendment will be requested from the Centers for Medicare and Medicaid Services.

iv. Factor G′ Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates of Factor G' for each waiver year are from the Senior and Long Term Care's Elderly and Physically Disabled Waiver for nursing facility level of care (recently approved in their waiver renewal). Projections for Waiver Years Two and Three were estimated to increase by 5%.

The 372 report for the first year of the waiver will provide more accurate data and if significant differences are reflected, an amendment will be requested from the Centers for Medicare and Medicaid Services.

d. Estimate of Factor D. *Select one:* Note: Selection below is new.

✓	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
○	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year

Waiver Year: Year 1—Year 5 (following pages)					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Adult Day Health Care	15 min	2	2005.28	1.94	7,780.49
Adult Residential Care	day	24	261.48	61.80	387,827.14
Case Management, Monthly	day	105	269	10.00	282,450.00
Case Management, 15 minute	15 min	0	0	13.75	0
Chemical Dependency Counseling	15 min	50	16	11.25	9,000.00
Day Habilitation	day	9	53.50	74.20	35,727.30
Habilitation Aide	hour	10	131.07	16.12	21,128.48
Chore	service	6	1.89	189.80	2,152.33
Homemaker	15 min	32	772.97	3.03	74,947.17
Meals	meal	21	155.07	5.00	16,282.35
Nutritional Counseling, Dietician	visit	2	5	25.00	250.00
Occupational Therapy	visit	50	4	19.75	3,950.00
PAS Nurse Supervision	hour	10	5.98	3.80	227.24
PERS, Installation & Testing	service	11	1.30	100.00	1,430.00
PERS, Monthly Rental	monthly	29	9.07	69.00	18,149.07
PERS, Purchase Only	service	1	1	129.22	129.22
Personal Assistance	15 min	53	1292.82	3.80	260,373.95
Personal Assistance	per diem	3	218.30	9.27	6,070.92
Prevocational Service	hour	9	431.84	7.06	27,439.11
Private Duty Nursing	15 min	15	946.77	5.56	78,960.62
Psychosocial Rehabilitation	Service (45-50 min)	50	56	51.66	144,648.00
Residential Habilitation (per diem)	day	1	275.66	131.46	36,238.26
Respite Care	15 min	5	773.92	3.03	11,724.89
Respite Care, per diem	day	1	155.55	140.00	21,777.00
RN Supervision	15 min	6	17.40	11.25	1,174.50
Specialized Medical Equipment	item	23	6.61	192.03	29,194.32
Specialized Medical Supply	item	4	93.34	5.75	2,146.82
Specially Trained Attendant	15 min	5	750	4.02	15,075.00

Waiver Year: Year 1—Year 5 (following pages)					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Supported Employment	15 min	4	16	10.75	688.00
Supported Living, per diem	day	1	254.94	208.00	53,027.52
Transportation, per mile	mile	64	817.06	0.13	6,797.94
Transportation, per trip	trip	3	117.20	10.00	3,516.00
Illness Management & Recovery	Service (45-50 min)	50	12	51.66	302,727.60
Wellness Recovery Action Plan	registration	20	1	140.00	2,800.00
GRAND TOTAL:					1,865,811.24
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					105
FACTOR D (Divide grand total by number of participants)					17,769.63
AVERAGE LENGTH OF STAY ON THE WAIVER					295

Waiver Year: Year 2					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Adult Day Health Care	15 min	2	2005.28	1.94	7,780.49
Adult Residential Care	day	26	261.48	61.80	420,146.06
Case Management, Monthly	day	125	269	10.00	336,250.00
Case Management, 15 minute	15 min	0	0	13.75	0
Chemical Dependency Counseling	15 min	50	16	11.25	9,000.00
Day Habilitation	day	9	53.50	74.20	35,727.30
Habilitation Aide	hour	10	131.07	16.12	21,128.48
Chore	service	6	1.89	189.80	2,152.33
Homemaker	15 min	32	772.97	3.03	74,947.17
Meals	meal	21	155.07	5.00	16,282.35
Nutritional Counseling, Dietician	visit	2	5	25.00	250.00
Occupational Therapy	visit	50	6	19.75	5,925.00
PAS Nurse Supervision	hour	10	5.98	3.80	227.24
PERS, Installation & Testing	service	11	1.30	100.00	1,430.00
PERS, Monthly Rental	monthly	29	9.07	69.00	18,149.07
PERS, Purchase Only	service	1	1	129.22	129.22
Personal Assistance	15 min	53	1292.82	3.80	260,373.95
Personal Assistance	per diem	3	218.30	9.27	6,070.92
Prevocational Service	hour	10	431.84	7.06	30,487.90
Private Duty Nursing	15 min	15	946.77	5.56	78,960.62
Psychosocial Rehabilitation	Service (45-50min)	50	56	51.66	144,648.00
Residential Habilitation, Per diem	day	1	275.66	131.46	36,238.26
Respite Care	15 min	5	773.92	3.03	11,724.89
Respite Care, per diem	day	1	155.55	140 00	21,777.00
RN Supervision	15 min	6	17.40	11.25	1,174.50
Specialized Medical Equipment	item	23	6.61	192.03	29,194.32
Specialized Medical Supply	item	4	93.34	5.75	2,146.82
Specially Trained Attendant	15 min	5	750	4.02	15,075.00
Supported Employment	15 min	4	16	10.75	688.00
Supported Living, per diem	day	1	254.94	208.00	53,027.52
Transportation, per mile	mile	64	817.06	0.13	6,797.94
Transportation, per trip	trip	3	117.20	10.00	3,516.00
Illness Management &	Service	50	12	51.66	302,727.60

Waiver Year: Year 2					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Recovery	(45-50min)				
Wellness Recovery Action Plan	registration	21	1	140.00	2,940.00
GRAND TOTAL:					1,957,093.96
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					125
FACTOR D (Divide grand total by number of participants)					15,656.75
AVERAGE LENGTH OF STAY ON THE WAIVER					307

Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Adult Day Health Care	15 min	2	2005.28	1.94	7,780.49
Adult Residential Care	day	26	261.48	61.80	420,146.06
Case Management, Monthly	day	125	269	10.00	336,250.00
Case Management, 15 minute	15 min	0	0	13.75	0
Chemical Dependency Counseling	15 min	50	16	11.25	9,000.00
Day Habilitation	day	9	53.50	74.20	35,727.30
Habilitation Aide	hour	10	131.07	16.12	21,128.48
Chore	service	6	1.89	189.80	2,152.33
Homemaker	15 min	32	772.97	3.03	74,947.17
Meals	meal	21	155.07	5.00	16,282.35
Nutritional Counseling, Dietician	visit	2	5	25.00	250.00
Occupational Therapy	visit	50	6	19.75	5,925.00
PAS Nurse Supervision	hour	10	5.98	3.80	227.24
PERS, Installation & Testing	service	11	1.30	100.00	1,430.00
PERS, Monthly Rental	monthly	29	9.07	69.00	18,149.07
PERS, Purchase Only	service	1	1	129.22	129.22
Personal Assistance	15 min	53	1292.82	3.80	260,373.95
Personal Assistance	per diem	3	218.30	9.27	6,070.92
Prevocational Service	hour	12	431.84	7.06	36,585.48
Private Duty Nursing	15 min	15	946.77	5.56	78,960.62
Psychosocial Rehabilitation	Service (45-50min)	50	56	51.66	144,648.00
Residential Habilitation, Per diem	day	1	275.66	131.46	36,238.26
Respite Care	15 min	5	773.92	3.03	11,724.89
Respite Care, per diem	day	1	155.55	140 00	21,777.00
RN Supervision	15 min	6	17.40	11.25	1,174.50
Specialized Medical Equipment	item	23	6.61	192.03	29,194.32
Specialized Medical Supply	item	4	93.34	5.75	2,146.82
Specially Trained Attendant	15 min	8	750	4.02	24,120.00
Supported Employment	15 min	6	16	10.75	1,032.00
Supported Living, per diem	day	1	254.94	208.00	53,027.52
Transportation, per mile	mile	64	817.06	0.13	6,797.94
Transportation, per trip	trip	3	117.20	10.00	3,516.00
Illness Management &	Service	50	12	51.66	302,727.60

Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Recovery	(45-50min)				
Wellness Recovery Action Plan	registration	23	1	140.00	3,220.00
GRAND TOTAL:					1,972,860.54
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					125
FACTOR D (Divide grand total by number of participants)					15,782.88
AVERAGE LENGTH OF STAY ON THE WAIVER					307

Waiver Year: Year 4 *(renewal only)*					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					
FACTOR D (Divide grand total by number of participants)					
AVERAGE LENGTH OF STAY ON THE WAIVER					

Waiver Year: Year 5 *(renewal only)*					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					
FACTOR D (Divide grand total by number of participants)					
AVERAGE LENGTH OF STAY ON THE WAIVER					

✓	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
○	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

ii. Estimate of Factor D – Concurrent §1915(b)/§1915(c) Waivers.